April, 1955

Canadian Hospital

- *Social worker on the hospital team*
- *Social service at Vancouver General*
- *Social service and teaching programs*
- *Trail-Tadanac Hospital high above the city*
- *George Findlay Stephens Memorial Award*
- *Hospital statistics for determining progress*

Canadian Hospital Association

St. Elizabeth Hospital bids goodbye to high laundry costs with new **Canadian** equipped plant!

saves linens, time . . . and $200.00 a month!

Another hospital laundry modernized by Canadian

At right, operator adds supplies to one of two Cascade Washers. Below, 40" Monex Open Top Extractor and 30" Solid Curb Extractor.

When administrators of 188-bed St. Elizabeth Hospital, North Sydney, Nova Scotia, invested in Canadian laundry equipment, they reaped these immediate and lasting benefits. Positive control of linen inventory, with greatly reduced new linen requirements. Higher quality finished laundry—both hospital linens and staff apparel. Faster return of linens to service, no delays! Ideal working conditions, with efficient use of space and easy-to-use equipment. All this, plus savings of over $200.00 a month!

When you plan a new laundry installation, or the modernization of your present facilities, call in Canadian. Your Canadian Laundry Consultant will survey your clean linen requirements, recommend the right equipment, most efficient layout—all without cost or obligation to you. Write or call for his services—today!

Uniforms for nurses and staff are completely machine-finished on easy-to-use Nurses' Uniform Press Unit shown above.

Fast economical ironing is done on this 4-Roll Streamline Flatwork Ironer. In left background, two Zone-Air Drying Tumblers.

You can depend on

your Canadian Laundry Consultant's advice in your selection of equipment from the complete Canadian Line. Backed by years of experience in planning and equipping laundries, he can help solve your clean linen problems. Ask for his specialized assistance anytime . . . no obligation.

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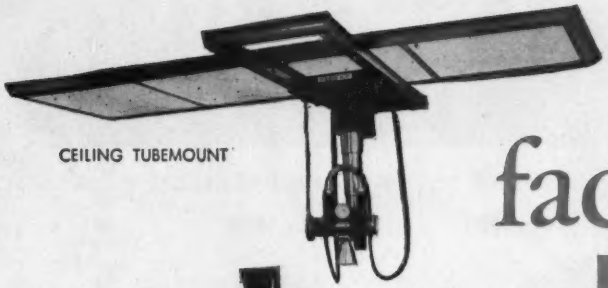
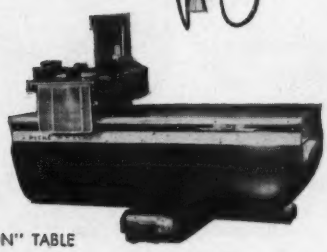


CEILING TUBEMOUNT



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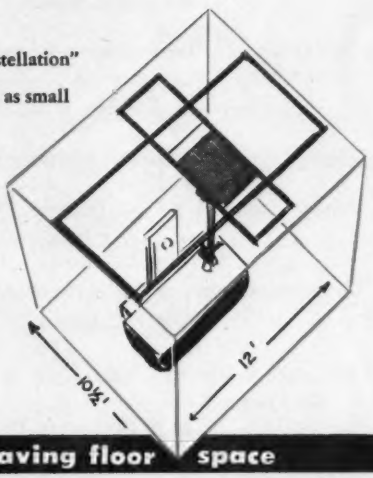
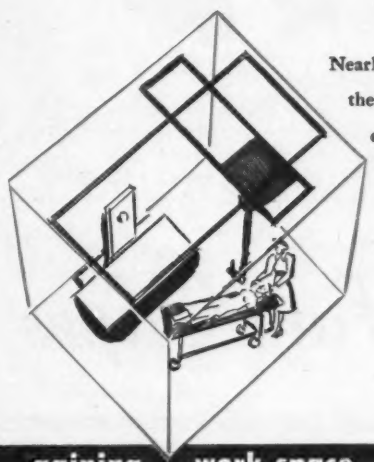
facts·figures

show how much you gain by using this "island" table and free-ranging x-ray tube

You can put a "Constellation" anywhere in a room as small as this because it's not bound to the Ceiling Tubemount



in saving floor space



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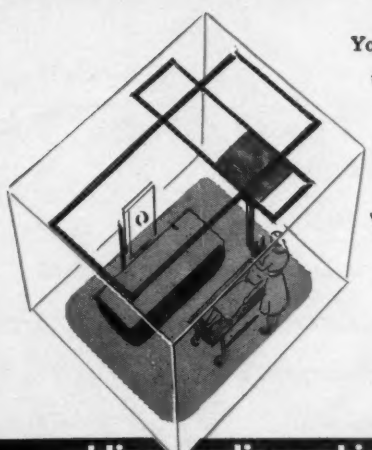

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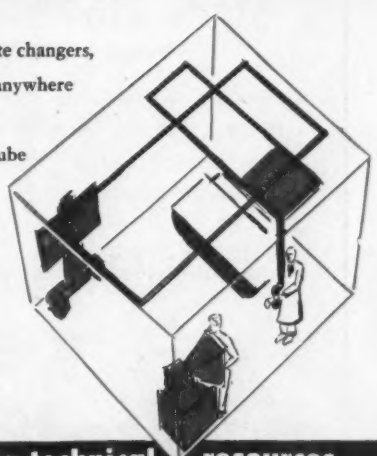
You can put cassette changers, Bucky stands, etc. anywhere around the room because the x-ray tube comes within 18" of any wall.



multiplying technical resources

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Contents

Vol. 32 **APRIL, 1955** No. 4

(For Subscription Rates, see page 92)

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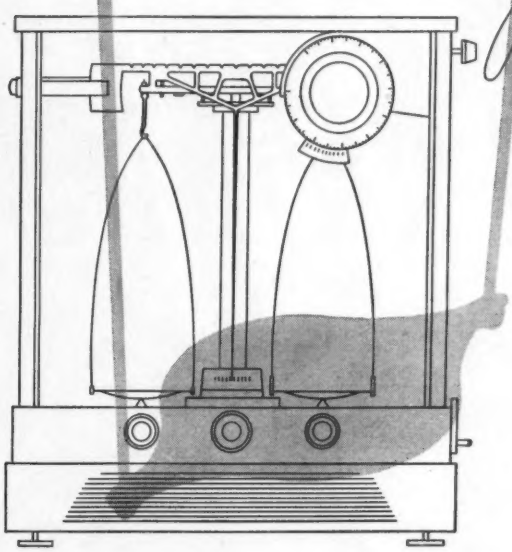

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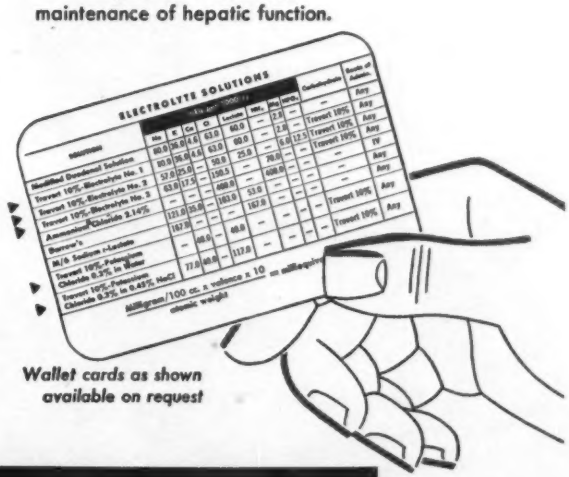

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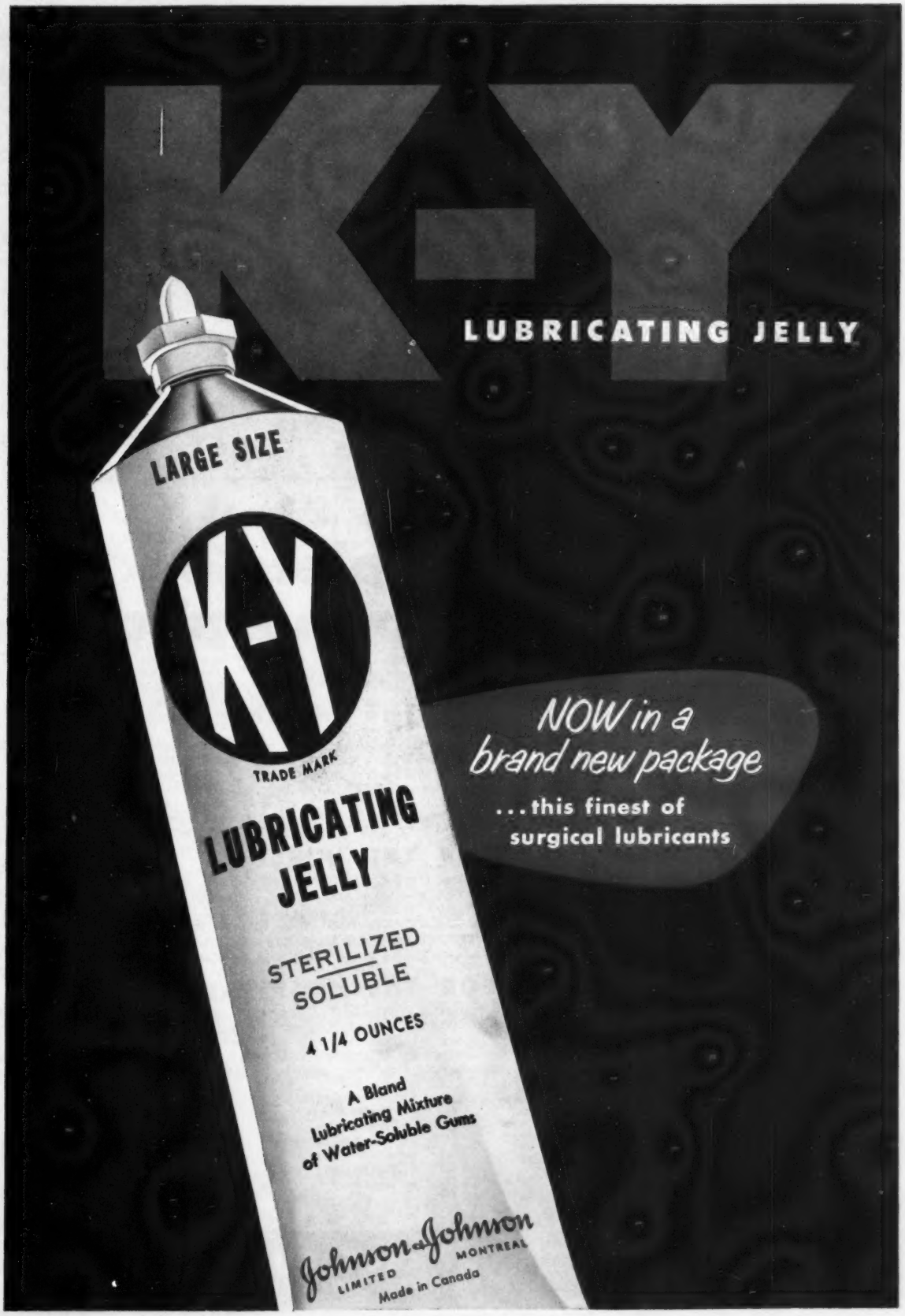
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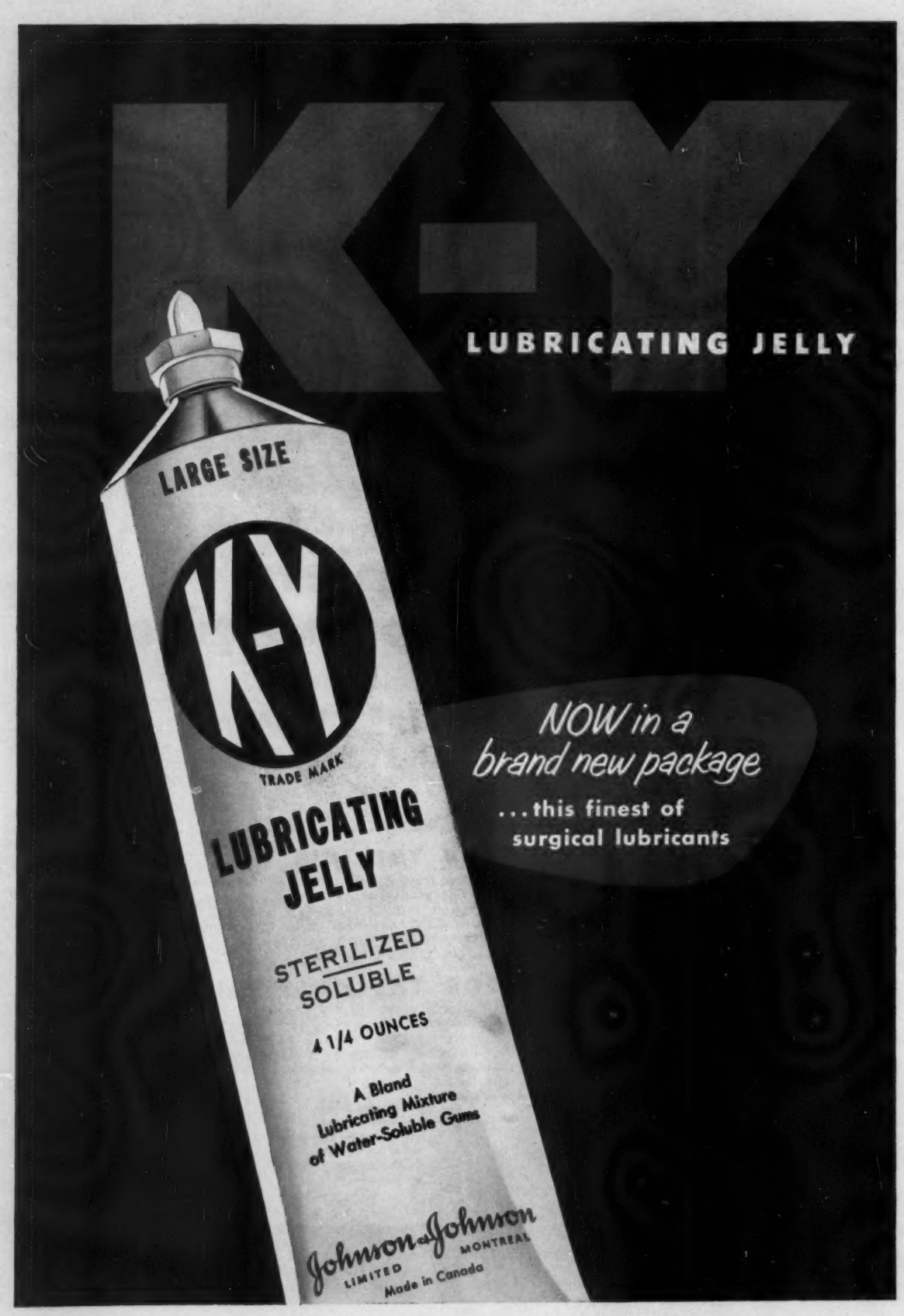
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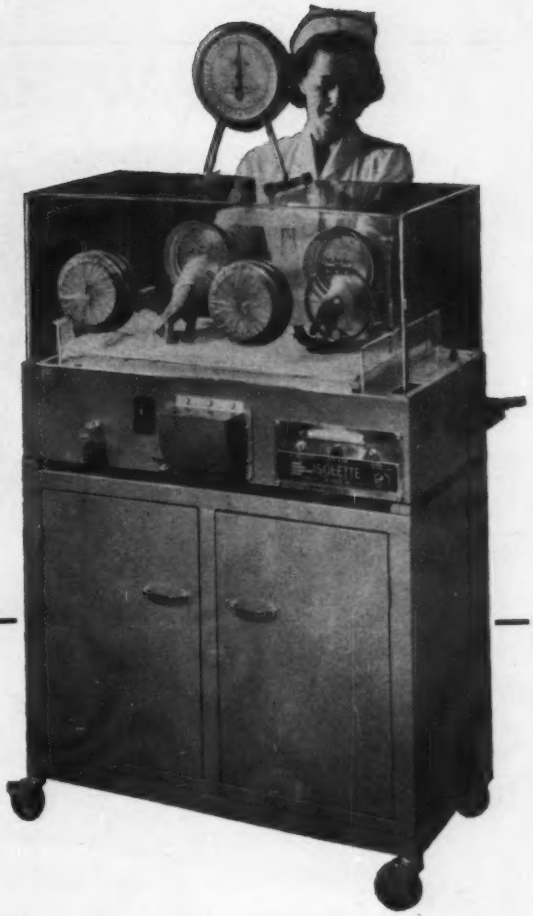
"Before purchasing any incubators, those in charge of premature care should carefully appraise all the available types..."[1]



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"excellent mechanical controls" — "The incubator which we have found most efficient is the Isolette . . . the atmosphere within the unit can be kept at a constant temperature and humidity . . . it affords excellent visibility . . . (and) ease of handling the patient . . .

"By placing the baby in an Isolette . . . he can be protected from respiratory infections, which might be lurking in the doctors and nurses who are in attendance."[4]

Useful as an isolation unit—"Individual air-conditioned incubators in which strict isolation is maintained at all times may be utilized for either the nonsuspect or the suspect infants . . . It may even be possible to omit an isolation nursery . . ."[5]

Protection from cross-infection by forced air circulation — ". . . individual isolation provided by Chapple's bed protected the baby from dangers of cross-infection . . . the infant is surrounded by conditioned fresh air drawn directly from outdoors and is further protected from all droplet infection . . . We now have four of the old-type Chapple beds and eight of the new-type 'Isolettes' and have at last achieved the ideal for which we aimed."[7]

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"Such incubators are expensive but certainly no more so than many another piece of hospital equipment that contributes to the saving of lives."[1]

1. Lull, C. B., and Kimbrough, R. A.: Clinical Obstetrics, Philadelphia, J. B. Lippincott Company, 1955, pp. 633, 634. 2. Hess, J. H., and Lundeen, Evelyn C.: The Premature Infant, ed. 2, Philadelphia, J. B. Lippincott Company, 1949, p. 43. 3. Davis, M. E., and Sheckler, Catherine E.: DeLee's Obstetrics for Nurses, ed. 15, Philadelphia, W. B. Saunders Company, 1951, p. 506. 4. Gross, R. E., and Ferguson, C. C.: Surgery in premature babies, observations from 159 cases, Surg., Gynec. & Obst. 95:631, 1952. 5. Gross, R. E.: The Surgery of Infancy and Childhood, Philadelphia, W. B. Saunders Company, 1953, p. 62. 6. Standards and Recommendations for Hospital Care of Newborn Infants, Evanston, Illinois, American Academy of Pediatrics, 1954, p. 58. 7. Clifford, S. H.: Infections of the newborn and premature infant, Penna, M. J. 53:25, 1950. 8. Dancis, J., and Cardullo, H. M.: Incubator care of the premature infant, Pediatrics 6:432, 1950.

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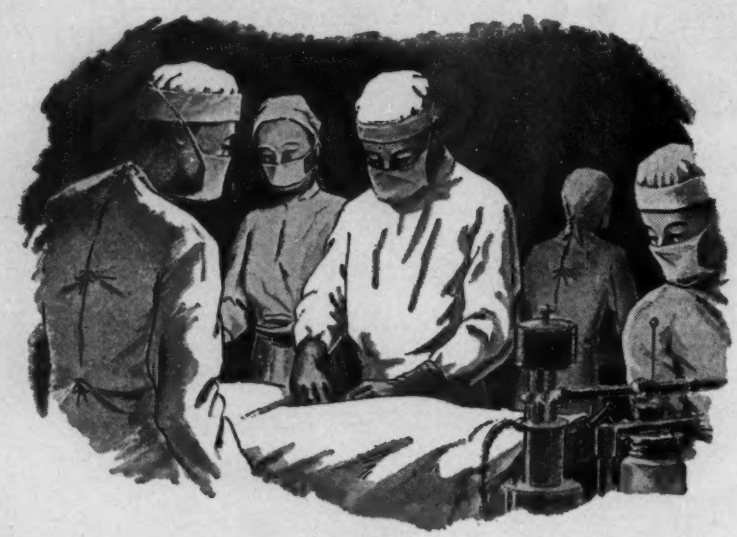

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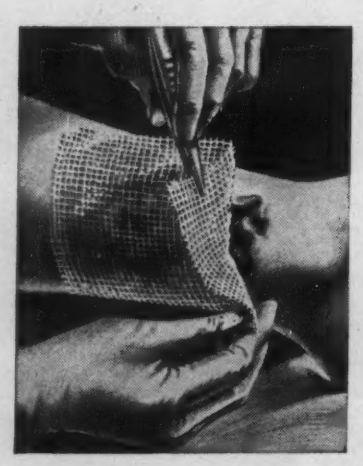

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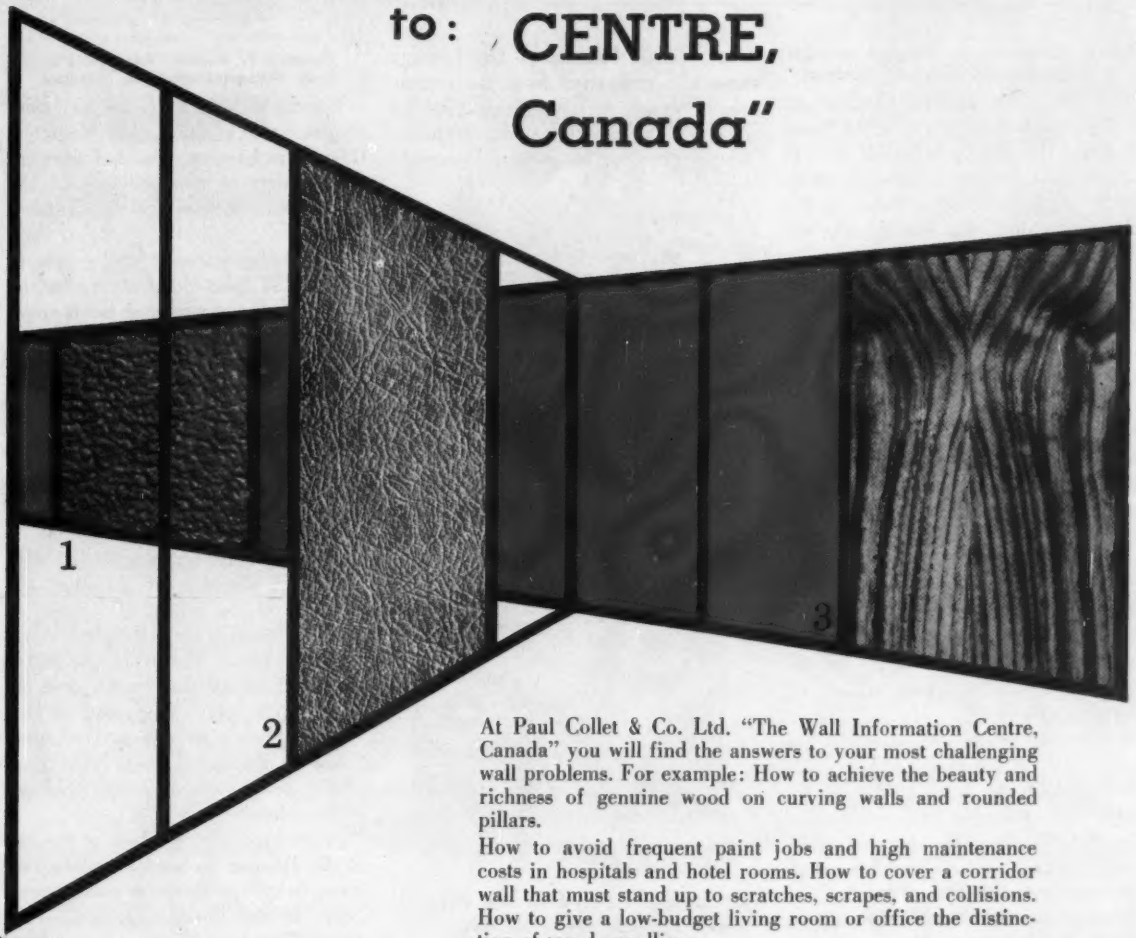

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◂ Notes About People ▸

Dr. R. Christie to be Physician-in-chief at Royal Victoria Hospital, Montreal

Dr. Ronald V. Christie has been appointed physician-in-chief of the Royal Victoria Hospital in Montreal, as well as professor of medicine and chairman of the department of medicine at McGill University. The appointment will be effective as of next Oct. 1st. Dr. Christie will succeed both Dr. Walter de M. Scriver and Dr. J. S. L. Browne. Dr. Scriver requested that he be relieved of his appointment as physician-in-chief in order to devote more time to private practice. Dr. Browne has been appointed professor of investigative medicine and chairman of the new department of investigative medicine at the university.

Dr. Christie received his early medical training at Edinburgh University in Scotland and came to Montreal in 1928 as senior resident medical officer at the Royal Victoria Hospital. While there, he won a scholarship for study in pathology at the University of Freiburg in Germany. He returned to Montreal in 1930 as research associate at the McGill University Clinic of the Royal Victoria. In 1933, he was awarded the Master of Science degree by McGill. After that he received appointments at various British hospitals, serving as professor of medicine at London University and vice-president of St. Bartholomew's Hospital in London.

* * *

Dr. Charles U. Letourneau Appointed to Northwestern

Dr. Charles U. Letourneau, formerly of Montreal, has been appointed director of the program in hospital administration at Northwestern University, Chicago. Dr. MacEachern will continue his association with the program as professor of hospital administration, with the title of honorary director. On accepting his new position, effective April 1st, Dr. Letourneau resigned as secretary of the Council on Professional Practice of the American Hospital Association, a post which he has held for four years.

A graduate in medicine and in law from McGill University, Dr. Letourneau also graduated from the course which he now directs. From 1946 to 1950 he was superintendent of Queen Mary's Veterans' Hospital in Montreal.

* * *

Administrator Appointed at Campbell River, B.C.

Arthur S. Lightfoot, administrator of St. George's Hospital in Alert Bay, B.C., has been appointed administrator to the 62-bed hospital to be constructed

Arthur S. Lightfoot

at Campbell River, B.C. He will commence his new duties in May.

Mr. Lightfoot served overseas in the Canadian Army during World War II and, in 1945, he commenced his hospital career as assistant administrator at the Nanaimo Hospital in Nanaimo, B.C. He resigned from this position in 1951 to become administrator of St. George's Hospital. Mr. Lightfoot successfully completed the extension course in hospital organization and management, sponsored by the Canadian Hospital Association.

* * *

Florence H. M. Emory Honoured

Tribute to an internationally known nurse, Florence H. M. Emory, professor emeritus of the University of Toronto School of Nursing, was paid by Dr. Sidney Smith, president of the university, at the unveiling of a portrait of Miss Emory last month. Dr. E. Kathleen Russell, director emeritus and founder of the school, unveiled the portrait which was the gift of the nursing school alumnae. The portrait will hang in the school auditorium.

* * *

Norman F. Mutter, Administrator Ross Memorial Hospital, Lindsay

Norman F. Mutter, who has been administrator of the Archer Memorial Hospital in Lamont, Alta., has accepted the position of administrator of the Ross Memorial Hospital in Lindsay, Ontario.

Mr. Mutter attended high school in Ottawa and spent three years with the R.C.A.F. He commenced his hospital career in 1947 when he joined the staff of the Kingston General Hospital, Kingston, Ont. When he left that hospital in 1953, he held the position of credit manager.

* * *

New Nursing Director for Peterborough Civic Hospital

Miss Fay Rutledge, Reg.N., has been appointed director of nursing and principle of the school of nursing at the Peterborough Civic Hospital, Peterborough, Ont. She will take active charge of the nursing service and the school next July. Since the resignation of Evelyn Robson last summer, the two positions have been filled by an acting director and an acting principal of the school.

A graduate of the school of nursing at the Toronto General Hospital, Toronto, Ont., Miss Rutledge spent several years in the nursing service of the Royal Canadian Navy, and was head of the nursing school at the RCN Hospital in Halifax. At present, she is completing a post-graduate course at the University of Toronto.

* * *

Appointments Announced by Government of Saskatchewan

Dr. Irial Gogan has been appointed director of the division of hospital administration and standards of the Saskatchewan Public Health Department. Dr. Gogan served in Eire, England, and Iraq before joining the provincial health department in 1953.

The new director of the psychiatric services branch of the Saskatchewan Public Health Department is Dr. F. S. Lawson, who previously served with

(Continued on page 16)

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The new wax base sweeping compound that is approved by flooring manufactures and recommended for all finished floors

High-grade oil base compound for wood and cement floors, where heavy soil conditions are encountered.

Canada's outstanding general-purpose oil base sweeping compound. Absorbs maximum volume of germ laden dust.

Sisal base recommended for use on smooth floors where soil accumulation is very heavy.

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Notes About People

(Continued from page 12)

the department as superintendent of the Saskatchewan Hospital at Weyburn from 1947 to 1948 and the Saskatchewan Hospital at North Battleford from 1948 to 1953. Dr. Lawson succeeds Dr. D. G. McKerracher, the branch's director since 1949, who has left to devote full time to the positions of professor of psychiatry at the University of Saskatchewan and head of the psychiatric department at the new University Hospital in Saskatoon.

* * *

Superintendent of Nurses Appointed at new Sudbury Memorial Hospital

Dorothy Monteith, Reg.N., of Washington, D.C., has been appointed superintendent of nurses at the new Sudbury Memorial Hospital, Sudbury, Ont. Construction of the six-storey building is nearing completion.

Formerly of Palmerston, Ont., Miss Monteith is a graduate of the school of nursing at the Guelph General Hospital and has taken post-graduate training in nursing and hospital administration in New York and Boston. Her last position was assistant to the director of nursing for a group of 10 hospitals operated as a federal project by the government of the United States.

• Tribute was paid to the chairman of the Brantford General Hospital, Brantford, Ont., Dr. N. W. Bragg, as he was re-elected for another term. The board of governors passed a resolution commending Dr. Bragg for his leadership.

• At the annual meeting of the Beausejour and District Hospital Board, Beausejour, Man., Reeve Edward Wojciechowski was installed as president and N. J. Kubish as vice-president.

• Glen W. Phelps was re-elected chairman of the board of the Soldiers Memorial Hospital, Orillia, Ont.

• The Board of trustees of the Wingham General Hospital, Wingham, Ont., renamed H. C. MacLean as chairman.

• Russ Inkster was named as president of the board to the Nanaimo Hospital, Nanaimo, B.C. Earle C. Westwood is the vice-president.

• J. E. Harris was re-elected chairman of the board to the Sarnia General Hospital, Sarnia, Ont. William Schofield is vice-chairman.

• A. M. Knight has been re-appointed chairman of the Clinton Hospital Association by the board of directors of the Clinton Public Hospital, Clinton, Ont.

• New chairman of the board of the St. Thomas-Elgin Hospital, St. Thomas, Ont., is K. M. Williamson. Dr. J. W. Snell is vice-chairman.

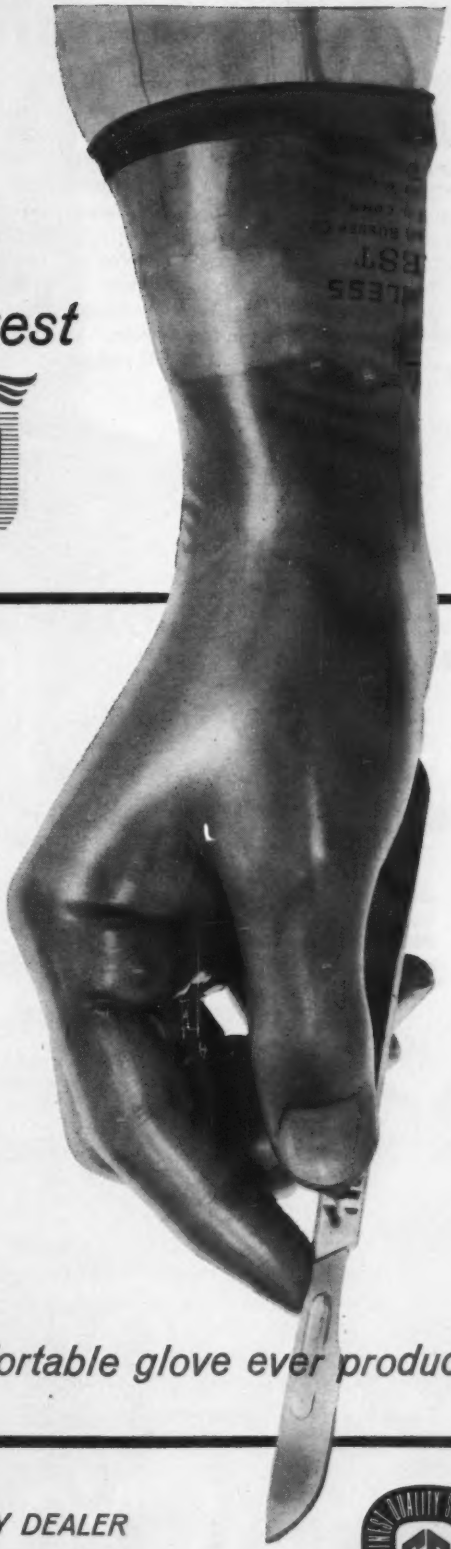
• At a recent meeting of the medical staff of the Hotel Dieu de St. Joseph in Bathurst, N.B., Dr. D. A. Thompson was elected president for 1955; Dr. L. M. Veniot, vice-president; and Dr. Emile Frigault, secretary. Committees will be selected so that each medical department will be under the direct supervision of a doctor.

• Mr. and Mrs. Rolv Kleiven, physiotherapists from the Skodsborg Hospital and Sanitarium, Skodsborg, Denmark, recently arrived in Canada. They have commenced their new duties at the

(Concluded on page 22)

ANNOUNCING

The new Seamless Crest surgeon's glove



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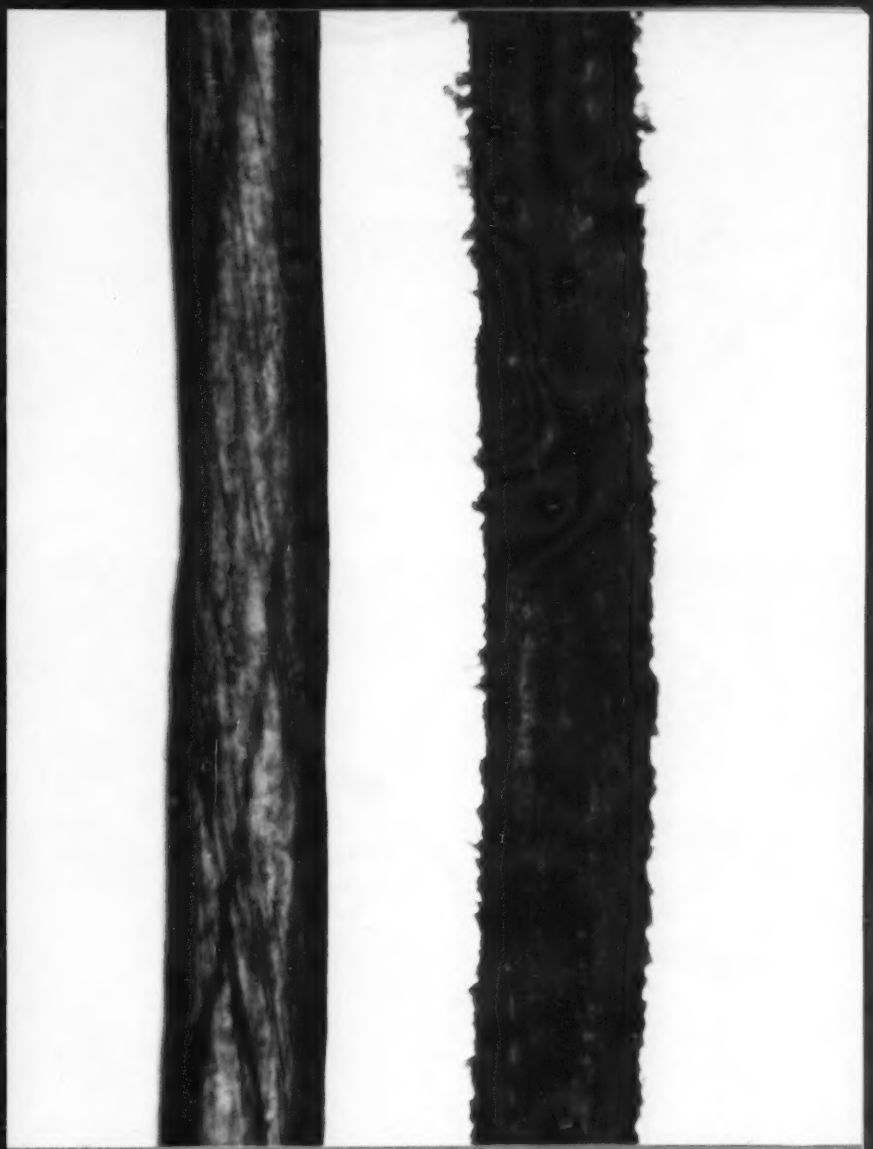
Research shows why D & G gut is stronger

PHOTOMICROGRAPHY SEES WHAT THE HAND CANNOT FEEL



Photomicrographs (unretouched) by E. J. Thomas, Stamford Laboratory of the Research Division of the American Cyanamid Company, Stamford, Conn.

Method used: dark field, transmitted bright field illumination, 138 x.
Material used: medium chromic gut, size 5-0.

D & G gut

Photomicrograph **shows the smooth surface of D & G SURGICAL GUT, with practically no fraying or roughness.** ***Reason:*** **Carefully controlled slitting of plies plus uniform twisting provides a smooth, well-bonded strand. No need to grind it to size. Gentle polishing gave the matte finish.** ***Result:*** **the full natural strength of each gut ribbon (ply) is preserved; the strand is not frayed by grinding.**

Another leading gut

Photomicrograph **reveals rough, frayed surface of another leading brand of gut. This has been ground to size. Gut processed in this way appears very uniform in diameter to the naked eye. But the photomicroscope reveals serious imperfections which may cause fraying and loss of strength when the knot is tied.**

see exhibit on next page ▶

SUTURES AND OTHER D&G SURGICAL SPECIALTIES

DAVIS & GECK INC

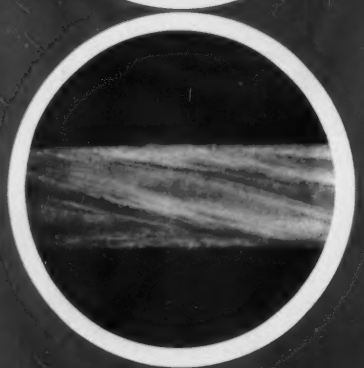
A UNIT OF AMERICAN Cyanamid COMPANY

DANBURY, CONNECTICUT

Photomicrography shows why D & G gut is more flexible

D & G GUT

Firm, even cohesion of plies is apparent in this photomicrograph of a D & G SURGICAL GUT suture. Reason: plies were twisted into a strand before suture was chromicized. Natural cohesive forces of moist untreated collagen firmly bond the plies together and hold the twist. Result: under stress, plies of the suture hold together. The D & G gut is more flexible and knot strength is greater.



ANOTHER LEADING GUT

Photomicrograph detects separate and distinct plies in a strand of another leading brand of surgical gut. Here each ply was chromicized before they were twisted into suture strands. Such "ribbon chromicizing" hardens the surface of each ply, decreasing the natural bonding action, lowering the flexibility and tensile strength of the suture.

Photomicrographs (unretouched) by E. J. Thomas, Stamford Laboratory of the Research Division of the American Cyanamid Company, Stamford, Conn.

Method used: dark field, reflected illumination, focus on crest of surface, 38 x. Material used: medium chromic gut, size 00.

see exhibit on previous page

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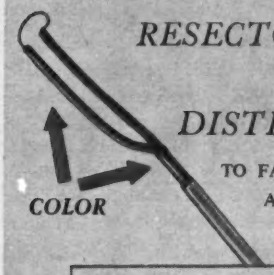
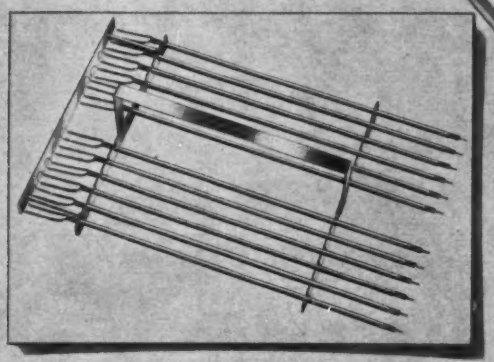
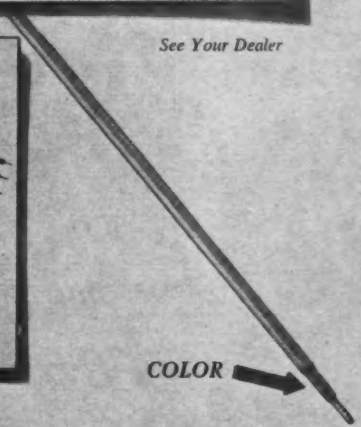


Loop Color	Instrument Size Fr.	Electrotome	Telescope
Yellow	24	Stern-McCarthy Standard Model.	68
Yellow	24	Stern-McCarthy Multiple Model and modifications.	68 and 68A
Grey	26	Stern-McCarthy Multiple Model and modifications.	68 and 68A
Green	28	Stern-McCarthy Standard Model and modifications.	68 and 68A
Blue	28	Stern-McCarthy Multiple Model and modifications.	68 and 68A
Black	28	Stern-McCarthy Standard Model.	68

See Your Dealer





Cat. No. 5155 Nesbit Loop Sterilizing Tray.

Cold disinfection is recommended for cutting loops and electrodes. The loops are placed in serrated openings provided and the tray is immersed in disinfecting solution of Urolocide or other disinfectant. A similar tray is provided for disinfection of telescopes.

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Notes About People

(Concluded from page 16)

Rest Haven Hospital in Sidney, B.C., which is operated by the Seventh-day Adventist Church.

* * *

● Jean Baptiste Jobin, M.D., F.R.C.P., (C), F.A.C.P., chief of the service of medicine, Hôtel-Dieu de Québec, has been appointed dean of the faculty of medicine at Laval University, Quebec. Dr. Jobin has been chief in medicine at Hôtel-Dieu since 1935 and holds the honorary degree of Doctor of Science of Laval for his contributions to science.

● Dr. G. R. Scott has been appointed chief of staff of the Peterborough Civic Hospital, Peterborough, Ont.

● Dr. W. J. Earle, formerly on the staff of the Ontario Hospital at Whitby is now at the Ontario Hospital at Smiths Falls.

● Eric Winkler was re-elected chairman of the board of the Hanover Memorial Hospital, Hanover, Ont.

● Chairman of the board of governors of the Queensway General Hospital, Toronto, Ont., is Crawford Gordon; N. S. Vanderploeg is chairman of the building committee. Construction of the new hospital begins this month.

Allan Memorial Institute Undertakes Research Project on Schizophrenia

Schizophrenia, the most serious and most prevalent of all mental diseases, is the subject of a large-scale research project at the Allan Memorial Institute of the Royal Victoria Hospital, Montreal, P.Q. For some time, the Institute has devoted a great deal of work to the treatment and follow-up care of patients after discharge. Dr. R. A. Cleghorn, director of the experimental laboratories at the Institute, is launching a three-year program to learn more about the disease from which about half of all mental patients suffer.

A grant of $33,000 for the year has been allotted to the project from federal-provincial funds. In addition, for the next three years, Dr. Cleghorn's team of workers will receive $23,000 annually from the Foundation Fund for Research in Psychiatry administered by Yale University, and $4,000 a year from the Supreme Council, 33rd Degree, Scottish Rites Masons' Northern U.S. Jurisdiction, which has long supported research in schizophrenia.

Learning from the Dictionary

You can learn more from a dictionary in ten minutes than in an hour from almost any other book. It is notorious how, on the way to find the word we want, our attention is distracted a dozen times, and from these chance encounters we return with richer profit than was our aim.

A good English (The Shorter Oxford) dictionary is indispensable. It is so easy to get the wrong idea of what a word means and to continue to use it incorrectly. And Fowler's *Modern English Usage* also will prove itself of daily value. And if one should find his time so occupied that he can spare only the fewest of minutes for out-side reading, these dictionaries will in a minimum of time furnish him not only with a maximum of instruction and profit but also with much pleasure and delight. A dictionary is a good book to read.—*J. C. Hossack, M.D., C.M.*

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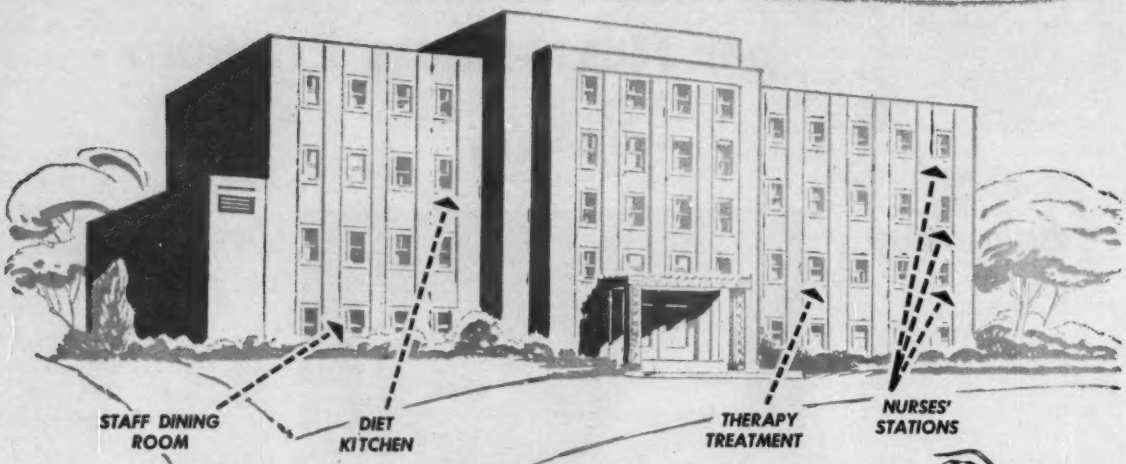
on every floor!



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Whatever your ice needs — there is a SCOTSMAN Automatic *Super Flaker* or *Super Cuber* to meet every one. The SCOTSMAN SC-100 *Super Cuber* is ideal for stations on every hospital floor. This low priced efficient *Super Cuber* will save time, work and money by providing low cost, sparkling, sanitary Super Cubes . . . big, round, solid, longer lasting cubes.

When flaked ice is needed for cold packs or therapy the SCOTSMAN *Super Flaker* supplies dry, hard, free-flowing Super Flakes. Super Flakes are made quietly without grinders, choppers or knives, using a mechanism which is the most dependable, yet simplest, ever designed.

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Harry Tang

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Kitchen Equipment (L. to R.) Model F4200 Fryer—Model K165B Griddle Broiler—Model 5130 Super Radial Fin Range—Model 5145 Open Top Range—Model 5783 SD High Shelf—Model 5786 SD High Shelf—Stainless Steel on all exposed surfaces.

Installation by Dundas Sheet Metal.

For years the Nanking Tavern has been a rendezvous for connoisseurs of Chinese dishes.

As with other famous eating places throughout Canada, this noted tavern selected Moffat-Vulcan Gas Cooking Equipment because of its unrivalled flexibility and capacity. Not only can this equipment handle any cooking need from the simplest to the most complex but there are also unlimited combinations and arrangements by which it can be tailor-made to any specific plan of kitchen operation.

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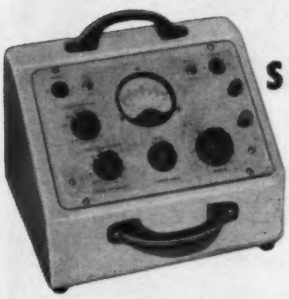

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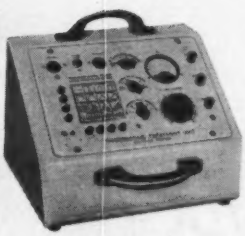

- Selective stimulation of denervated muscle.
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- Push-button wave-form selection.
- Diagrammatic wave-form indicator panel.
- Very portable — weighs approximately 21 lbs.

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- Inkless recordings.
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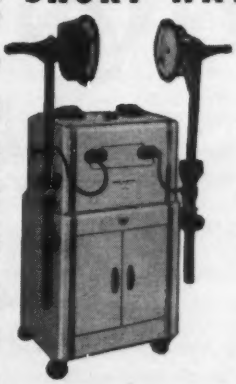

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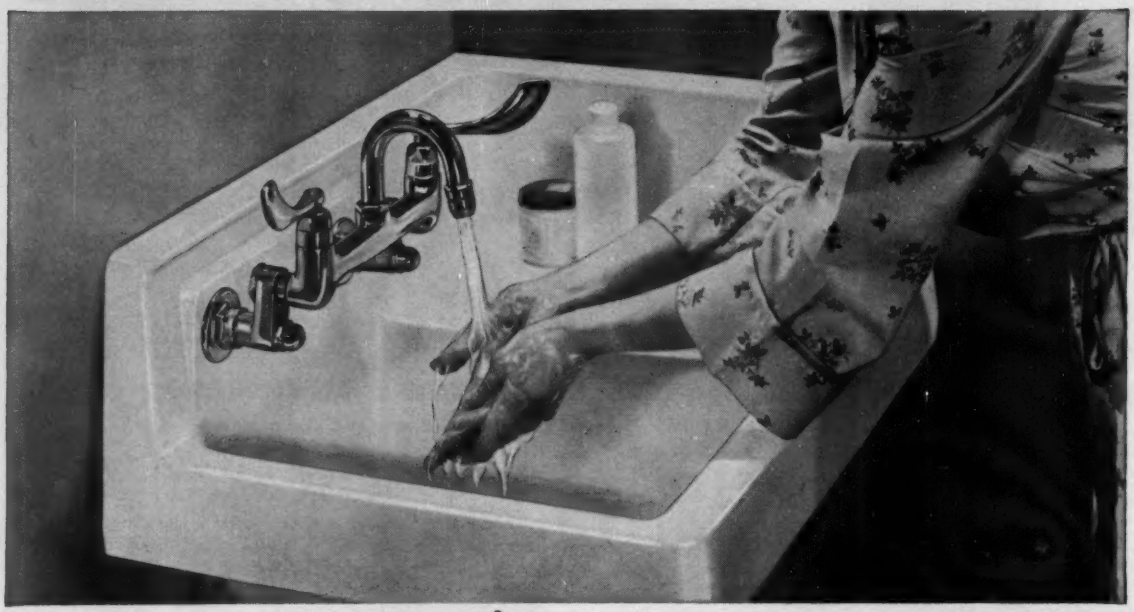

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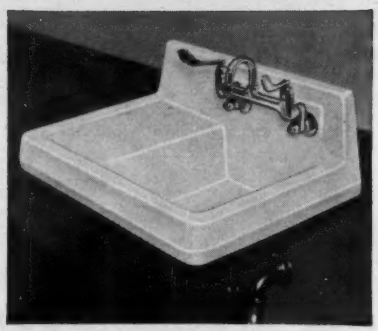

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1. Removing much lost motion, hundreds of needless steps, and many unnecessary tasks from a nurse's day.

2. Aiding in making the profession of nursing more attractive by making the work easier, faster, more pleasant.

Developed with the help of hospital experts to meet specific hospital needs, Crane fixtures conform to the best in good hospital practice and sound hospital management.

Specially designed for installation in patients' rooms and wards, Crane's new Hygiene Lavatory is equipped with wrist-action Dial-ese controls. And it has an integral shelf for water pitcher, toilet articles, and other patient needs.

It can be placed in either corner of the room or bathroom or along the wall. By being conveniently near and easy to use, it is a standing invitation to convalescent patients to care for themselves instead of ringing for a nurse.

The Hygiene is the only lavatory especially made for patients' use, and is a good example of the way Crane meets specific hospital needs with specialized design.

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W. Douglas Piercey, M.D., Editor

The Canadian Hospital

Obiter Dicta

A Message from Your President

WHETHER OR NOT society is becoming over-organized poses an academic problem. The fact remains that if hospital trustees, administrators and all others interested in the provision of the best possible hospital services for the people, wish to be free to function efficiently, they must be organized effectively at the municipal, provincial and federal levels.

At the biennial meeting to be held in May, your Board of Directors of the Canadian Hospital Association welcomes the opportunity of meeting with the official delegates and others from each province in Canada in order that we may give an account of our trusteeship for the past two years and also receive direction in matters of policies for the future.

The two major functions of the Canadian Hospital Association are negotiation at the federal level and education. Delegates are urged to come to Ottawa prepared to present the views of the province which they represent.

—*A. C. McGugan, M.D.*

New Faces

AS ONE attends hospital conventions, meetings, and institutes, one sees many new faces. This indicates that hospital personnel change frequently—something which must not be overlooked in developing any hospital educational program. Not only do staff changes call for understudies for all key positions; but these changes also mean that training programs must be repeated at frequent intervals.

If everyday hospital routines are to be carried out efficiently, senior hospital people must realize that a constant program of education within the institution is essential. One administrator was concerned to find that two years after he had shown a film on public relations to all his staff, a considerable number of his present personnel had not seen it. Familiarity with such important subjects as fire regulations, personnel policies, disaster plans, and public relations is a necessity and these should be brought periodically before various hospital employee groups. A good media for the dissemination of such information is a hospital newsletter or bulletin; and many hospitals now utilize these as regular features.

There are also frequent changes on hospital governing boards. The orientation of new trustees to the physical layout of the hospital, its over-all objectives, and education in hospital matters, is a responsibility which must be assumed by other board members and the administrator himself. A planned program drawn up by the chairman of the board in consultation with the administrator will prove to be of great assistance to the new trustee.

Directors of nursing, particularly, have been concerned for some time with changing staff. Ward procedures and hospital administrative policy, essential to a smooth-running ward, are misunderstood frequently because new people are not familiar with the routines. Ward procedure books are a great help, providing they can be kept up to date.

Keeping abreast of modern trends in hospital administration is not easy. It entails extensive reading on the part of the administrator and department heads, attendance at regional, provincial, and national hospital meetings, and transmitting the information gained, in turn, to various staffs. Every media which is available should be used if the plan of keeping all hospital employees fully conversant with new trends and developments is to provide the maximum benefit.

Educational programs for staff are not peculiar to hospitals, as they are something which industry today has to provide constantly. Modern methods of communication such as printed brochures, visual aids, films, and house organs, can all contribute to the dissemination of information of value to employees. One should not assume that the employee knows as much about his job as he should know. Any educational program sponsored by the hospital will be welcomed by employees and the majority will avail themselves of the opportunity to improve their knowledge and thus benefit their work.

Not only is the individual hospital administrator concerned with in-hospital education for the staff of his own hospital, but continuing education is also of concern to provincial and national hospital associations, as it is the very essence of programs for conventions, regional meetings, and institutes. The publication of your official

journal is for the same purpose. Moreover, it must be remembered that ideas presented or published a few years ago will be new to many in the hospital field today.

As mentioned above, it is our belief that the majority of hospital personnel are interested in learning more about hospitals and about their positions. This belief has been strengthened because of the wide acceptance which the extension courses in hospital organization and management and for training medical record librarians have received across Canada. It would appear that there is a need for such courses and that the demand will continue for some time to come, if not indefinitely.

There is a limit to what national and provincial associations can do for individual hospitals in the field of education. In the final analysis, it rests with each hospital to utilize all means available to keep its employees informed regarding the hospital and its operation. Hospitals which have developed active in-service educational programs have found that the standard of employee efficiency has risen.

Another Member of the Hospital Team

SOCIAL SERVICE as it applies to hospitals is a term which has been interpreted quite differently in many institutions and even in the same institution at various times. It is quite evident that the concept of social service as it pertains to in- and out-patients has undergone considerable change in the past few decades. In the beginning, social service was usually thought of as relating solely to the financial status of patients attending the hospital; and those staff members who were charged with the responsibility of investigating the background of patients were not specially trained for their positions.

While doctors have been aware for a long time that social elements in the patient's background play an important part in his reaction to his ailment and influence treatment, the acceptance of the trained medical social worker as an integral part of the hospital team has been slow in developing. In large part, this has been due to a lack of understanding by the other staff members as to the benefits that could accrue to the patient by bringing the trained medical social worker into the team. The team, itself, has grown considerably in recent years. In the early days, team work in patient care was carried out by doctors and nurses; then as medical science became more complex, various ancillary groups were added such as dietitians, pharmacists, laboratory and x-ray technicians, physiotherapists, occupational therapists and now the social worker.

This month, we are publishing three articles on hospital social service—pages 33 to 38. Each points out some of the many reasons — specialization of the medical staff, shorter stay, early ambulation and today's emphasis on rehabilitation—why there is a growing awareness of the importance of the medical social worker to the hospital.

Tribute to Sir Alexander Fleming

SIR ALEXANDER Fleming, the discover of penicillin, is dead. Since 1942 penicillin has become known to millions and the world is a much safer place because he lived. The past decade has seen many new drugs developed and a number of these are a direct result of the discovery of penicillin.

Sir Alexander Fleming received many honours. He was a nobel prize winner, was knighted in 1944; and a modern laboratory bears his name and the name of his teacher, the Wright-Fleming Institute of St. Mary's Hospital, London, England (see page 49, *The Canadian Hospital*, January, 1955). These honours he richly deserved. He would be the first to admit that he did not set out to find a powerful antibiotic. It was back in 1928 that he noted he was having "a little trouble" with an experiment because of contamination of a culture with a mould. World War II created the need for an intensified search for better drugs to control infections and provided the added incentive. With the help of co-workers, he pioneered the practical application of penicillin and gave scientists around the world the impetus to search for more. Today, to penicillin there has been added a group of antibiotics and, together, they have ushered in a new era for mankind —making our day the safest era yet known for humanity, as far as man's power of controlling bacterial disease is concerned. It is a sad commentary on human progress that through the possible improper use of atomic energy the same era has ushered in the day also which permits man to wipe himself off the face of the earth.

The discovery of penicillin was no invention and in a sense it was an accident. Yet it points up the lesson that humanity is indebted frequently to the painstaking work of research scientists who around the world are at work making experiments constantly, recording their findings and exchanging knowledge, which at the time seem to have little practical value. Such is the stuff from which modern miracles grow.

For your information

SHORTLY AFTER the April issue of *The Canadian Hospital* reaches our readers, they will receive the 1955 edition of the *Canadian Hospital Directory*. Inaugurated in 1953, the Directory is now published annually by the Canadian Hospital Association. In somewhat more than 200 pages is contained much information about hospitals and allied health organizations.

The compilation of the Directory is not a simple task. It has involved considerable time on the part of our staff for the past four months. The information which it contains has been supplied through the assistance of individual hospitals, government departments, and many organizations active in the health field of Canada. Without the help of many individuals and groups, the Directory would have been impossible. Our grateful thanks is given to all who assisted us and to our advertisers whose financial support made its publication possible.

The Directory has five major sections—institutions, educational programs, organizations, films and library, and a buyers' guide. It is a most valuable reference manual for many—trustees, administrators, department heads and personnel and is also of great assistance to the officers of many health organizations and government departments. Commercial firms who ordinarily do business with hospitals will find it useful for their sales staff.

The answers to many enquiries received at the secretarial offices of the Association are to be found in the Directory. Keep your copy handy. When you need information about Canadian hospitals, look in the *Canadian Hospital Directory*—you will find your answer quickly.

Social Worker on the Hospital Team

Rev. Henri Légaré, O.M.I., M.A., D.Soc.Sc.,
Executive Director, Catholic Hospital Association of Canada, Ottawa.

IN RECENT years, universities throughout the United States and Canada have organized courses in medical social work which are specialized branches of their schools of social service. The first year is basic training and the second year is specialized training. There are social workers for family groups or child agencies and also for hospitals. The object of these courses is to train social workers to serve in medical settings of various kinds: hospitals, clinics, health departments, health agencies, and so on. A statement, regarding the standards to be met by the medical social service departments in hospitals and clinics, was issued by the American Association of Medical Social Workers. The need of medical social workers is justified in a broad sense by the preamble to the standards.

"It has long been recognized by practising physicians that many social elements play an important part in the incidence and control of disease and that there is a need to know the patient as an individual person in relation to the environment in which he lives or works; his capacity to participate in a plan of medical treatment, his obligations and his material and personal resources. Nevertheless, the physician is seeing his patient in a hospital or clinic where the patient is isolated from his natural environment and the physician is hindered from understanding as fully as is desirable the social factors which may be contributing to the patient's illness or retarding his treatment and convalescence. It is important to know how effectively the clinic or hospital patient can use the resources of the medical institution and of the community and it will often be necessary to assist him to carry out the plan of treatment advised by the physician if he is to have as early and as complete restoration to health as possible."

The text goes on to explain that medical social service has developed in the hospitals as a service to the patient, the physician, the hospital administration and the community in order to help meet the problems of the patient whose medical need may be aggravated by social factors and who, therefore, may require social treatment which is based on his medical condition and care.

An address presented at the convention of the Associated Hospitals of Alberta, June, 1954.

Primary Aim

The object or the aim of the hospital is the care of the patient. This simple assertion is too general: it means much more than it says. One often wonders if hospitals today, having evolved into businesses and/or bustling scientific centres, have not become dehumanized in this economic and/or intellectual process and transformation. Is the hospital team considering the patient as just another numerical unit added to the many others already in the hospital or does it still cling to certain fundamentals inherent to human nature that are to be found in every patient? Do the members of the hospital administration ever find time to deepen, by reflection and meditation, the meaning of the purpose of their institution? Do the members of the medical staff, divided into many specialties, ever consider the patient as one human being or do they look only upon certain organs they are about to treat? As Dr. Richard McGraw, instructor in psychiatry and internal medicine at the Minnesota University Hospital, wrote: "You will all know that with the coming of specialization, doctors are no longer fulfilling many of the functions they did previously. Doctors used to be their own social workers, public health officers, and so on. Now, medical services are divided into different specialties and ancillary group services."

Richardson has compared what has happened to medical care to the Humpty Dumpty who fell off the wall, broke into many pieces, and is lying about all disjointed. He raises the question of who is going to put Humpty Dumpty back together again and, of course, this question of reintegrating medical care is a concern of medical educators at this time.

Rev. Henri Légaré

The other member of the hospital team, the nurse, would like to consider her patients as persons; but the numerous duties imposed on her by the shortage of staff often prevent her from doing so.

These questions make one wonder if in hospital work, the right attitude towards the patient is really the sole interest of our institutions. The patient is a human being, this is a well-known fact. All admit that there are certain fundamentals in this human being which constitute the charter of our care of the sick. The patient is a psychic unit, a structural unit, a social unit and finally a transcendent unit that tends towards God.

"Medicine," as says Pope Pius XII, "is concerned with looking upon the human body as a high precision mech-

anism whose parts fit in with each other and are connected with each other. The place and the characteristics of these parts depend on the whole. They serve its existence and its functions. This conception is more applicable still to the soul whose delicate workings are assembled with even more care. The various psychic faculties and functions form part of the whole spiritual being and subordinate themselves to the final end. What constitutes man is principally the soul, the substantial form of his nature. From it, ultimately, flows all human life. In the soul are rooted all the psychic dynamisms with their own structures and their own organic laws. It is the soul which nature charges with the regulation of all energies insofar as these have not yet reached their final determination.

"The patient is also a structural unit. Man is an ordered unity with a constitution whose purpose is determined by the end of the whole and subordinated to this end the activity of the parts according to the true order of their value and functions. Whoever studies the constitution of real man should in fact take as his object existential man, that is, man as he is, such as his natural dispositions, the influences of his media, education, his personal development, his intimate experiences and external events of men. It is only this complete man who exists."

"Man is also a social unit. What we have said up to now concerns his personal life. The psychical includes also his relations with the exterior world." A patient is a man, a social being, who belongs to the universe, societies and associations of all kinds. By entering a hospital he is cut off in a certain way, in a certain manner, from all these societies, from his work, from what would constitute his social background. We must remember this in the treatment of patients.

"A patient is finally a transcendent unit tending towards God". I will not stress this because all know that the patients entering hospitals have spiritual needs. Oftentimes when these spiritual needs are looked after, the treatment becomes easier.

Value of the Medical Social Worker

One might think that I have been wandering away from my topic in stressing, at some length, the nature of the patient. But, if the goal of medicine is to be achieved and the care rendered is to include consideration of the patient's total needs, the philosophy of the care of the patient must become part and parcel of a total program of the institution. I have tried to prove that the patient who is the hospital's main concern, is a rather complex being; always, I would say, determined by the psychic element in him. As the founder and pioneer of medical social service in America, Dr. Cabot wrote: "It is possible for the patient to suffer from disturbances of his stomach, his heart, or other portions of his anatomy, all because of rules of the spirit, fevers of the mind, moral degenerations, fatigue, sorrows, remorse, and worry. It is because of this inter-relationship of mind, body and estate that the medical social worker believes she has a unique contribution to offer in the total care of the patient in the form of medical social case work".

A medical social worker does not differ in any way from any other social worker. Her technique is the same — case work; but, in this instance, it is medical case work. To determine the place of this hospital worker, it would be best to show you the advantages and the value of the social worker to the doctor, to the nurse, to the administrator, and to the community as a whole. The social worker is a professional person and as such must be given a professional status. Too often, even in large hospitals, the doctors, the nurses and the administrator look upon the social worker as a very ordinary person and sometimes as an intruder. But they must remember that if the social worker is to accomplish her task, she will need their co-operation.

The Social Worker and the Doctor

Is the medical social worker of any help to the doctor? The medical social worker, as a member of the professional medical team concerned mainly with the welfare of the patient, makes a particular contribution to the efficacy of medical care. Her goal, which is the adequate care and health of the patient, is that of the other members of the team. She deals with the social problems that are connected with, or that result from, illness and the problems that interfere with recovery. She will gladly make the patient fully understand his situation, and thus help to prevent his illness from becoming a disabling experience. She helps him make his own decisions regarding the different choices offered him in his medical care. Should it be difficult for him to arrive at a conclusion, (or should none be suitable to his present condition), she helps him face the situation. She aids the patient to accept the doctors' diagnosis and inevitable recommendations. She interprets the social aspects of the medical problems to the doctor, to the patient, and to his family. She gladly assists the patient in making plans for the future, thereby helping him to take full advantage of community resources and to make the most of his own possessions. Thus, in helping the patient to regulate his situation, she encourages him to use his judgment and energy; and she is always standing by ready to assist, in case of need. This is a most important aspect of her work with the sick, because, as you all know, the sick feel more dependent than well persons. By handling the patient's fears and other emotional bewilderments with cleverness, she hastens his recovery. A good example of this can be found in many surgical cases. By all her good deeds, there is no doubt that the medical social worker is a very important factor in lessening, and even preventing, disability in the patient; and she often helps him to avoid complete invalidism which could well occur.

Should a careful study indicate that the illness is caused by social factors, the success of the treatment prescribed will depend upon the social worker's ability to deal with the situation. Her responsibility is also to try to prevent the development of social problems that may result from illness; and, if they are present, she will treat them. Thus, she may help the doctor in diagnosing the illness, particularly by obtaining the patient's social background. When the patients are admitted to the hospitals, they are sometimes very concerned with the financial difficulties caused to their family. In such cases, a competent and intelligent social worker will be glad to meet the patient. After having obtained from him, all the necesary details, in short the true picture of the situation, then she will help the doctor in treating the patient.

. . . and the Nurse

The social worker can help the nurse, and the nurse can also help the

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History and Organization of a

Social Service Department

Kenneth R. Weaver,
Director,
Social Service Department,
The Vancouver General Hospital,
Vancouver, B.C.

MEDICAL social service developed because of an existing need in hospitals. It was a gradually apparent need and has developed very slowly across the continent. At the Vancouver General Hospital the first "social service nurse" was added to the staff in 1912. From such beginnings, we have grown to the point where today, although still in a period of transition, we have become a recognized department of the hospital, employing only graduate social workers and working very closely with the medical and nursing staffs in the treatment of the patient.

Medical social work, like all organized social work, is very young in years of experience. Its development, as one of the professions which deal with human problems, has undergone many changes in a short span of time. Probably these services developed because of an awareness or growing social consciousness about people who are in dire need. The growing urbanization in our culture brought with it changes in the family as a unit of our society. Education, religious instruction, recreation, employment, and the care of the ill moved out from the home. Hospitals became popular and crowded. This created the problem, in many cases, of getting the patient back to the community, with a plan which would prevent him turning up the next day at the emergency department. The need for nursing home and boarding home care was established. Free care for the medically indigent became a necessity. Personal and family problems arose, *e.g.*, a mother could not respond to medical treatment properly if she knew her children had been left alone at home.

As our knowledge and experience grew in all the fields of social service, we found that it is not good enough just to provide tangible services for people as was originally done. We have found that because of inter-personal needs, people can and do create difficult situations or symptoms for themselves. It is necessary to come to understand individuals within the total context of their life situation.

Today, in social work in the medical setting, we work carefully with the doctor and nurse, not only in providing community resources according to a type of need indicated, but also supplying information as to the social and emotional components of the illness, and, where indicated, working with the patients to help them to come to a better personal and social adjustment. As a result, our referrals can come from both private and staff wards; and our services are available regardless of the economic status of the patient.

The changes in social work thinking over the years are very definitely reflected in the organization of the social service department in the Vancouver General Hospital, which will now be outlined.

The Women's Auxiliary to the Van-

Members of the social service department at the Vancouver General are, standing left to right: K. R. Weaver, director; Dolores Geernaert, stenographer; Mary MacInnes, caseworker; Mrs. L. McDonald, secretary; Dorothy Longley, caseworker; Mrs. G. Green, driver-clerk; Mrs. R. Perkins, admitting clerk; Mrs. Norine Anderson, caseworker; Sheila Naimark, caseworker; Dr. L. E. Ranta, and Walter Rudnicki, supervisor. Seated are: Mrs. Sarah Walker, caseworker; Jean Cochrane, caseworker; Mrs. Pat Murray, caseworker; Florence Clayden, caseworker; and Mrs. Richenda Crawford, supervisor.

couver General Hospital was responsible for the development of the social service department. The members are still very active in providing services and contributing to the developing philosophy of social work. At first these volunteers provided services themselves in the way of comforts for patients and the payment of some of their debts. However, the social needs of the patients increased to the point where volunteer efforts had to be supplemented by paid staff. The women's auxiliary paid for the salary of the social service nurse out of funds collected on tag days. The general purpose was seen as a need to investigate and to assist needy cases among the sick and convalescing poor of the city who were patients of the hospital. There was a great deal of concern about the plight of single, homeless men and the need to develop nursing homes for them. During the years 1918-1935, the social service department workers placed babies for adoption directly from the hospital. In 1919 the social service nurse took charge of the out-patient department. By 1920 the staff consisted of two persons and a director of social service was made responsible to the director of nursing.

The women's auxiliary to the hospital was paying for all of these services which now included a secretary and a car. By 1926 the hospital had grown to 900 beds and the auxiliary had exhausted itself financially and disbanded; so social service was taken over by the hospital administration.

Period of Development, 1927-1952

The volume of work increased in the 1930's and the out-patient department was reorganized. The social service nurse was left responsible for determining eligibility for free care and a social service worker retained that function up until 1954 in the out-patient department. Already, however, there was a growing concept of a new role which was stated as being "to supplement medical treatment of the patient with social treatment in clinic, ward or home, and aid the physician through the knowledge of the patient's home condition or point of view which requires adjustment, to make medical treatment more effective." More training became necessary to enable workers to handle these problems; and in 1932 the first social work student to have a field placement in the hospital arrived.

The year 1934 marks the progress of the department as the first trained social worker was added to the staff. This was a direct recognition of the need to have on the staff a person whose background of training provided a basis for the understanding of the problems with which social workers were now being faced. Over the years there were gradual additions to the staff and, whenever possible, professional social workers were hired. The student program was enlarged and both in-patient and out-patient functions were developed. In 1939 the department of social work was separated from the department of nursing. Workers, as they were added to the staff, were placed in specific services. Those who were placed in the out-patient department still continued to spend a great deal of time determining eligibility. On the wards, hospital discharge planning became the biggest role of the social worker, although more time and staff was needed to cope with family problems; mental and emotional instability; adjustment to illness; and the problem of the unmarried mother.

In 1947 a casework supervisor was added to the staff with the co-operation of the medical board. This prepared the way for a better service to patients by developing staff within the department. A few years later there was further recognition of the need for the services of a professionally trained worker in the semi-private pavillion, and this position was authorized.

The Department Today

The department is now a separate, administrative unit within the hospital. The director of social service is directly responsible to the assistant director, medical; and through his office to the director and the board of trustees. Having the assistant director, medical, as functional officer is an excellent arrangement, as it gives closer liaison between social service and the medical treatment team of interns and residents. Also, the present incumbent in this office, Dr. L. E. Ranta, is a man of great social consciousness and a much respected leader in community activity concerning health and welfare.

The department now consists of 12 social workers, which includes a director, two supervisors and nine case workers. There are four clerical workers; a secretary, a stenographer, a driver clerk, and an admitting clerk. The department was reorganized in September, 1952, when the present director took office. Part of the reason for this was a desire to set the department up on the basis of the Standards for Hospital Accreditation issued by

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THE VANCOUVER GENERAL HOSPITAL

Notice of Referral to the Social Service Department

Date .....

Patient's Name ..... Nursing Unit .....

Unit No. ..... Clinic .....

Medical Diagnosis .....

.....

Reasons for Referral:

1. Social History .....
2. Family Problem .....
3. Emotional Problem Affecting Illness .....
4. Rehabilitation Plan .....
5. Appliance .....
6. Financial Assistance .....
7. Discharge Plans .....
   (a) Nursing Home .....
   (b) Boarding Home .....
   (c) Institutional Care .....
   (d) Home .....
8. Other .....

Remarks:

Doctor .....

Social Worker's Report:

Social Worker .....

Social Service Department's

Participation in Teaching Programs

Lawrence E. Ranta, M.D., D.P.H.,
Assistant Director, Medical,
Vancouver General Hospital,
Vancouver, B.C.

THE DEVELOPMENT of medical social work arose from a new challenge. Advances in medical science introduced complex methods in health restoration, requiring an apportionment of the tasks of medical care. Out of this need developed the medical team composed of a variety of medical and non-medical specialists. The medical social worker is included in the latter group with nursing, dietetic and technical specialists.

Medical social work is a new field in comparison with many of the disciplines represented on the medical team. It is so new that some medical social workers still have difficulty in quickly finding the position they must play on the team in order to make the most effective contribution. But it is of more significance that some "captains" and other players on the team fail to be fully aware of the potential talents for team-play embodied in the medical social worker. Obviously, the solution of this problem lies in two-way communications; this is a continuing challenge for the medical social worker and for all those who comprise the medical team.

Opportunities for interpretation and the bridging of gaps were pesented by various courses at the Vancouver General Hospital, offered by the hospital itself or through its affiliation with certain courses of the University of British Columbia.

Participation in Medical Training

For the future welfare of patients, medical practitioners should be aware of the services provided by social workers in all phases of their activities. To this end, students in the Faculty of Medicine of the University of British Columbia are introduced early to social services. In the public health course of the first year, members of the class come into contact with social workers during an orientation survey of health and welfare services offered by official agencies of the community. This occurs during the first week of the students' attendance at medical school.

In the following year of the public health course, which deals with a comprehensive study of public health and welfare facilities, the medical students study the activities of various welfare agencies, such as the Children's Aid and the Family Welfare Bureau. Thus, in the third year, when the students commence clinical studies on a full-time basis, they have already been introduced to the social work activities outside a hospital setting. During the third and fourth years, the social service department of the hospital participates in the education of the medical student. Formal lectures are few in number and are confined largely to interpretation of the role of the medical social worker in co-operating with the physician's management of psychiatric cases. Most emphasis is given to interpretation during the medical students' training in the out-patient services. Here, the medical social worker can demonstrate the values of an integrated team approach to the medical problems of the ambulatory patient. This demonstration is augmented by the medical social workers attached to the teaching wards of the hospital where the in-patient's problems serve as a focal point uniting the combined talents of all services.

The author

An informal contact is maintained after the medical student graduates and returns to the hospital as an intern. Interns from other medical schools are given orientation periods with the social workers while engaged in out-patient services. The intern who develops an awareness of the social worker's function during undergraduate days has a much greater opportunity of carrying over this information to the care of his patients.

It is natural that some difficulty should occur between the medical social worker and the physician who graduated before the social worker's value in a medical setting had been clearly established for other than the basic functions of the "almoner." Under these circumstances, awareness of social work functions can develop only through individual interpretation by workers on the wards or by contributions to ward rounds in the presentation of a patient's problems. Although this area has value as continuity to previous association, it cannot substitute for interpretation to the medical student while his pattern of practice is unformed and information can be readily integrated into the broadening picture that unfolds before him during his undergraduate training.

Participation in Nurse Training

No less important is an assurance of mutual trust and co-operation between the nurse and the medical social worker. Perhaps, even more than with the doctor, the medical social worker comes into contact with the nurse.

The social service department co-operates with the School of Nursing of the hospital by giving a series of lectures to each class. In these lectures the student nurse is informed of the function of hospital social service and of the service rendered to the com-

munity by agency social workers.

This information is supplemented by contacts of the medical social worker with the student nurse on the wards. Here, the team approach to problems of the patient is given exemplification. It is only through this practical arrangement that proper interpretation can be assured.

As the School of Nursing of the hospital provides training for students enrolled in the School of Nursing of the university, each nursing class entering in the spring contains a number of students who have already spent two years at the university and are destined to return for specialization in public health nursing or clinical supervision. As many of these students become teachers of nursing practice and leaders in their profession, an interpretation of the social worker's role in the medical setting is of special value, for through them, the team approach to the problems of the patient can be perpetuated and expanded. Moreover, at an early stage of the public health nurse's training, she begins to accept the social worker as a partner in the care of the patient. As health departments are increasingly undertaking programs which necessitate the utilization of social work consultants on their staffs, a long-term value can be placed upon early interpretation of the social worker's function to the nursing students.

Hospital Administration Training

The Vancouver General Hospital is affiliated with the School of Commerce of the University of British Columbia in the provision of an undergraduate course leading to a degree of Bachelor of Commerce with a Diploma in Hospital Administration. The final phase of the course consists of seventeen months at the hospital receiving combined didactic and practical training. In the practical phase, the administrative students, as well as administrative residents from other university hospital administration courses, are assigned to the social service department for one week. The student is attached to the head of the department, whom the student "shadows" for the week, and finally prepares a report on the activities of the department which may contain suggestions regarding improvements in the department services. It will also show the interrelationship between the social service department and other hospital activities as they pertain to the welfare of the patient.

The education of administrative interns and members of the administrative staff is continued by including presentations from the social service department in an annual series of workshops. These are designed primarily to give administrative interns an opportunity for oral presentations as well as to serve as in-staff training and refresher periods.

Participation in Dietitian Training

A series of lectures is given to students of hospital dietetics. This includes an explanation of social services in the community as well as in the hospital. The dietitian is a member of the modern treatment team and she must be aware of the services provided by other members of the team. This orientation enables her to gain some knowledge of the problems of patients which comprise the principal tasks of the social service department and, in particular, the student is made aware of environmental, psychological, and emotional problems, which may relate to food.

In Social Service Training

The hospital is affiliated with the School of Social Work of the university and provides opportunities for instructing social service students in a medical setting. Social work students are placed primarily in the out-patient services of the hospital for practical experience in dealing with patients. This stage of training is under combined supervision of the hospital and the School of Social Work. Obviously, this arrangement is of value to both the hospital and the university. It is essential for the hospital to play a positive role in training medical social workers if their experience prior to graduation is to be brought to a level requisite for employment in a hospital setting. This participation has value to the university since nothing can substitute for practical experience gained in a medical setting under the guidance of experienced personnel.

Value of Participation

No easy method exists for the evaluation of a program which merely amounts to an explanation of the work of one group of workers to several other groups. Moreover, the amount of time which can be devoted to an educational program by persons who have a service task to perform is necessarily limited for the primary function of the department must be maintained, namely, to provide social service for the patient. Nevertheless, it should be recognized that nothing is more stimulating to a department nor maintains its efficiency more effectively than participation in a teaching program. It exposes the department to constant searching criticism which ensures a continuous review of methods and objectives. The increasing numbers of referrals of both staff and private cases for social service, as well as the number of requests for participation by the department in the in-staff training of various groups, give direct evidence that the integration of the medical social worker into the medical team is moving forward. There is no doubt that the program could be more effectively developed, were it possible to assign the function specifically to an education co-ordinator in the social service department.

Additional evidence of the value of the program is seen in the medical staff's acceptance of the contribution of the medical social worker. An example of this is seen in the participation of the head of the department in the activities of a medical committee which has undertaken a research project dealing with the rehabilitation of patients in one of the nursing homes affiliated with the hospital.

Participation in the training programs of the hospital and the university can be justified only if the patient profits from the efforts. There can be little doubt of the profit. The smoothness of operation of the medical team is essential for efficiency. This is the primary criterion of the quality of medical service; but success depends upon the whole team knowing the role expected of every member. Obviously, education is essential to achieve this in the first place and continuing refreshment must be undertaken to maintain it.

The by-product of participation in the training programs is felt in the social service department. Besides the stimulatory nature of teaching and learning, it is heartening for a new discipline to win its way on merit into the ranks of long established professions, some of which have suffered the viscissitudes of history for hundreds of years. Aid and recognition from such disciplines create a closer harmony of purpose and work to the advantage of everyone—especially the patient. •

To be presented at biennial meeting

George Findlay Stephens Memorial Award

DR. ANGUS C. McGugan, president of the Canadian Hospital Association, has announced on behalf of the board of directors that the George Findlay Stephens Memorial Award will be conferred upon Mr. Percy Ward of Vancouver. The award, which was established by the Canadian Hospital Association in memory of the late Dr. George Stephens, is bestowed in recognition of noteworthy service to the hospital field in Canada. The presentation will be made at the forthcoming biennial meeting of the Canadian Hospital Association to be held in Ottawa, May 9th to 11th.

History of the Award

Dr. George Findlay Stephens died in April, 1948, after a lifetime of service to Canadian hospitals. He administered two of Canada's leading hospitals, the Winnipeg General and the Royal Victoria in Montreal. For six years, from 1939 to 1945, he was president of the Canadian Hospital Association, then the Canadian Hospital Council. During these years extensive demands were made upon him, particularly in solving the many problems created by World War II. He was regarded as one of the outstanding authorities on hospital administration on the North American continent.

The George Findlay Stephens Memorial Award was established in 1949. The Canadian Hospital Association decided that the board of directors would select recipients on the basis of their contributions to hospital administration, with emphasis on personal efforts in advancing the efficiency of Canadian hospitals, in developing regional and national associations, and in fostering social progress. Particularly, recognition is given to constant service and leadership over the years.

Percy Ward

Percy Ward has been well known to hospital people in Canada and abroad for a long time. His career, more varied than most, has had many facets including military service, local hospital administration, provincial government hospital inspection, and active participation in local, national and international hospital associations. Since 1948 he has been secretary of the British Columbia Hospitals' Association. A forthright writer and public speaker, his wealth of knowledge of local, provincial and national hospital situations has made him an invaluable guide and counsellor.

The recipient was born in Sheffield, England, on November 29, 1882. Following education in the public schools of Wolverhampton and Birmingham, he served in the South African War from 1900 to 1904, wherein he received the King's and Queen's medals with two bars. For some time he was vital statistician to the Department of Health, Orange River Colony, South Africa.

Mr. Ward came to Canada in 1909 and for some years was engaged in the real estate business. He continued his interest in military training and between 1911 and 1915 was granted the King's commission successively as lieutenant, captain, and major, with certificate of fitness to command in the field in military engineering. In 1915 he went to France and served in the Ypres salient, Somme, and Vimy Ridge.

The interest which Mr. Ward has had in hospitals since the early days in South Africa came to fruition in 1933 when he became administrator of the North Vancouver General Hospital. In 1936 he was appointed assistant advisor on hospital services for the government of British Columbia and in 1937 as inspector of hospitals. In the same year he became the provincial government's representative at the Canadian Hospital Council meetings. Already a member of the Council's committee on accounting, he was appointed chairman in 1937 and held that office until 1949. In 1948 he retired from the provincial government service and assumed his present position as executive secretary of the British Columbia Hospitals' Association.

Percy Ward

Mr. Ward's wide interest in hospital work and his diversified knowledge of hospital administration were soon recognized beyond his own province. He was vice president of the American Association of Hospital Accountants in 1946 (and an honorary life member) and has been a director of the Canadian Hospital Association since 1949. He has served on many committees, frequently as chairman, on such varied subjects as mental hospitals, nursing, physiotherapy, chronic illness, and accounting. He has written many articles on hospital topics which have been published in hospital journals in Canada and the United States.

Percy Ward has been attending meetings of the Canadian Hospital Association for many years. He has been a very effective spokesman for the province of British Columbia, first as a provincial government representative and latterly as a delegate representing the provincial hospital association. While Mr. Ward has never been reticent in presenting the viewpoint of his adopted province, his vision of the hospital picture in Canada has been national in scope.

As chairman of the Committee on Accounting and Statistics of the Canadian Hospital Association, he laboured diligently for over 10 years to bring about standard accounting for the hospitals of Canada. When the *Canadian Hospital Accounting Manual* was published in 1952, as the result of much intensive work on the part of the staff of the Dominion Bureau of

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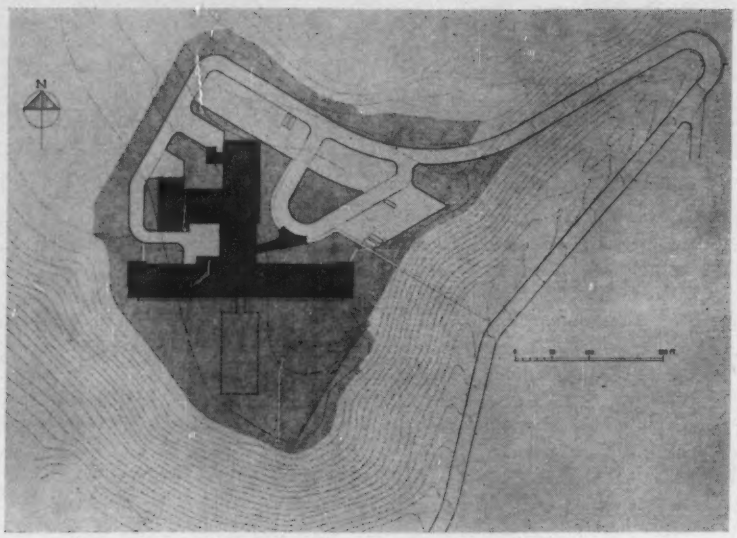
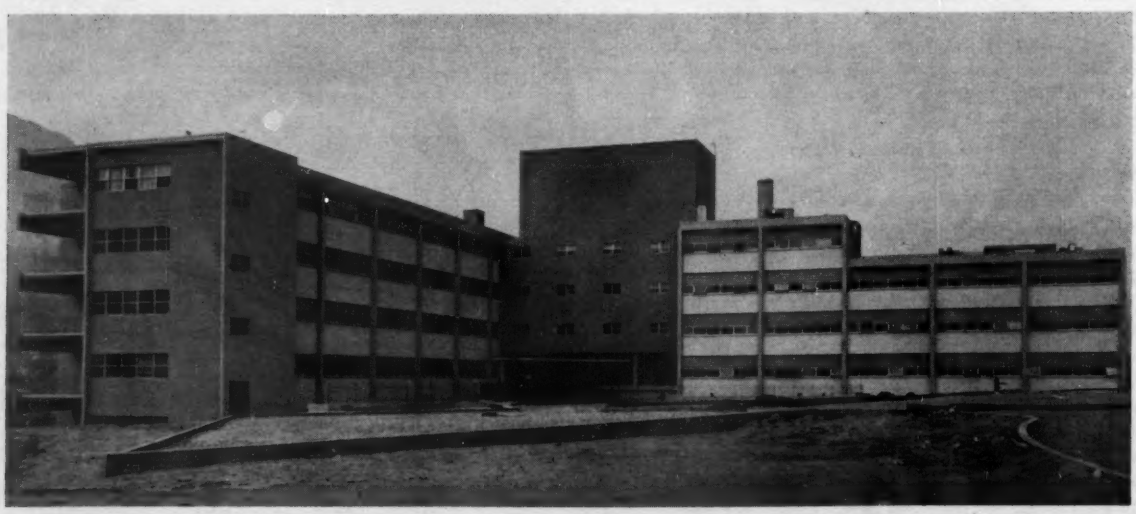


Perched high above the city—

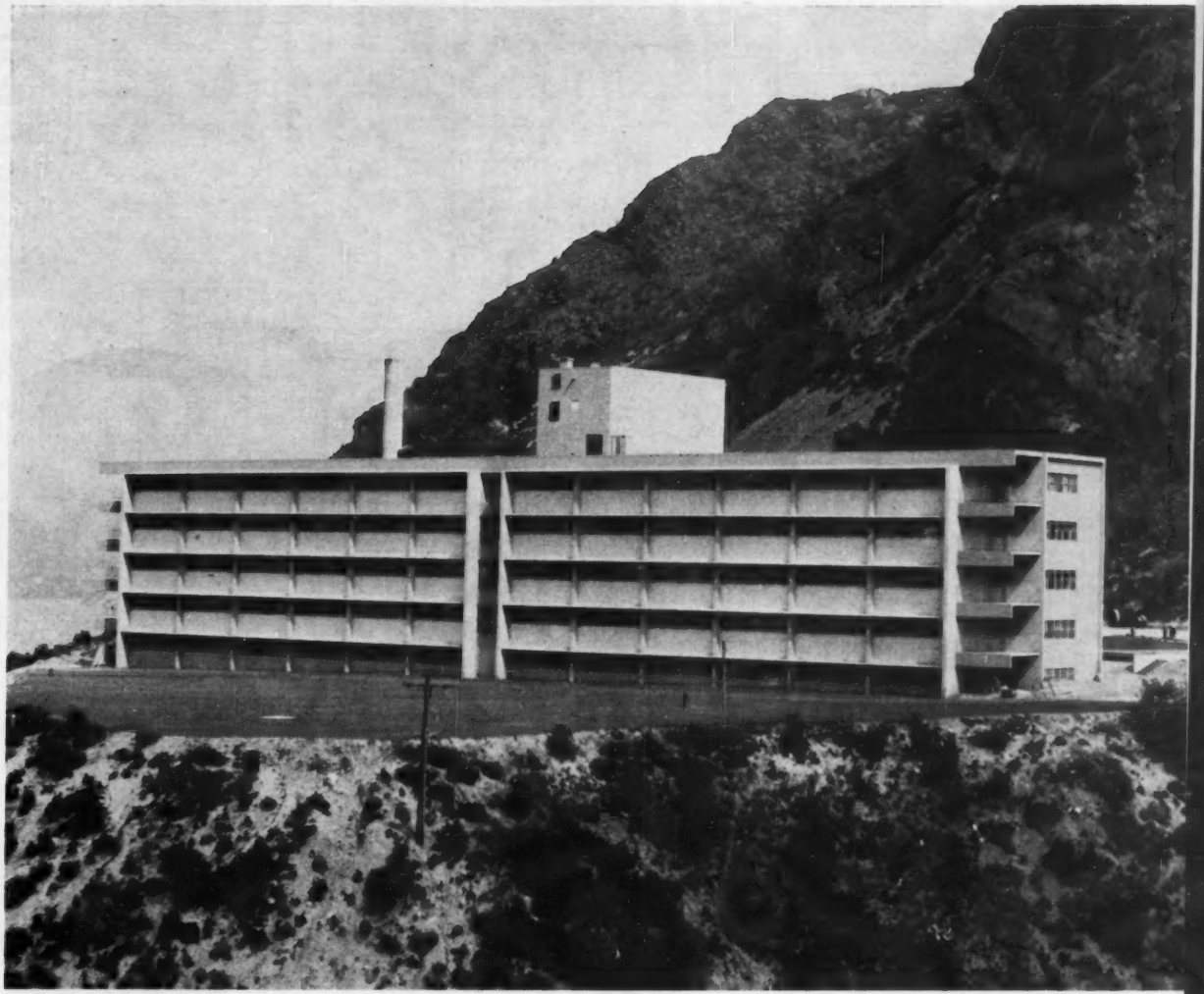
New Hospital for Trail-Tadanac

THE EVENTS leading up to the planning and construction of the new Trail-Tadanac Hospital constitute a long story of over-crowded conditions, one not uncommon in other parts of the province and throughout Canada. Over a period of 20 years, this situation, as shown in the annual public statements, became chronic, with increasing general dissatisfaction on the part of the public, employees, and medical staff members. A natural and healthy increase in the area's population had been a forerunner of the apparent need for better and more extensive health services, including a new hospital centre. The Trail-Tadanac Hospital no longer confines its activities to its two municipalities (which include the employees and families of the large industrial plant of the Consolidated Mining and Smelting Company of Canada Limited, "Cominco," widely known not only in Canada but throughout the United States and abroad) but to a great portion of the West Kootenay District in the interior of British Columbia as well. Referrals from the surrounding area represent approximately 50 per cent of all patients. There is a well organized and progressive medical staff giving specialty service in most of the surgical and medical fields. Despite a drop in the average length of stay, due to improved methods of treatment, the year 1949 saw hospital occupancy reaching a dangerous level. During 1950, the occupancy frequently reached 100 per cent, necessitating makeshift arrangements in order to accommodate emergency cases.

Investigations and surveys were conducted by hospital board members on a voluntary basis prior to 1948. Due to the foresight of these board members a suitable site was purchased



This front view of the hospital shows the canopied entrance.



This side of the hospital contains the patients' rooms. The over-hanging "solar slabs" shade the rooms from direct sunlight.

during this year on a bench overlooking the city, in East Trail. Consultation service was given voluntarily by well informed key personnel of the Consolidated Mining and Smelting Company of Canada Limited. After years of planning, Sharp and Thomson, Berwick, Pratt, of Vancouver, B.C. were appointed as architects for the new 150-bed hospital.

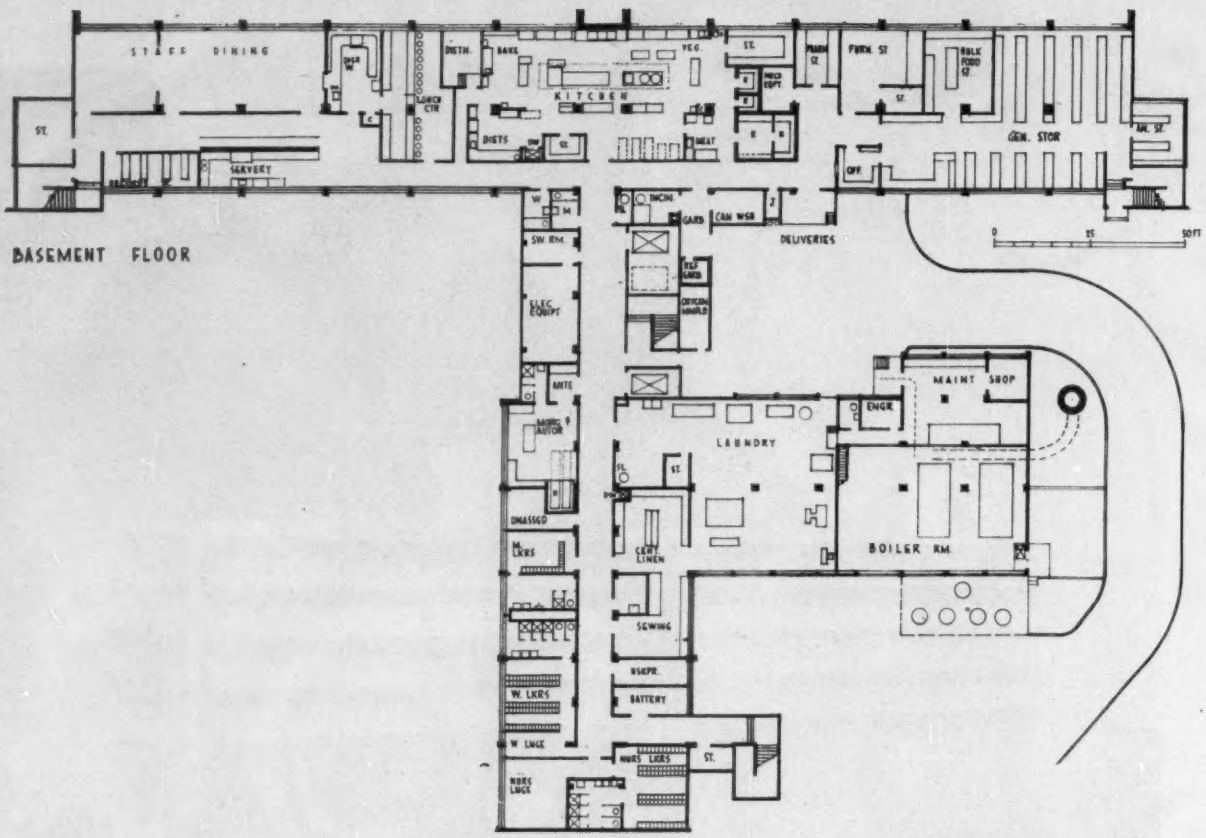
The city of Trail and the municipality of Tadanac have always worked together in promoting civic projects and were strong in their support of the new hospital. The following figures show how the costs of construction were met: 5 per cent—a gift of "Cominco"; 10 per cent from the taxpayers of the city of Trail; 19 per cent from the taxpayers of the municipality of Tadanac; 10 per cent from federal government grants; 56 per cent from provincial government grants. The total construction costs, excluding furnishings and site, were $1,919,810. The gross cubage is 1,276,000 cubic feet and the gross area, 113,490 square feet. The cost per bed was $12,800 and per cubic foot, $1.50.

To supplement the furnishings and equipment already on hand, generous donations were received from organizations and individuals in Trail and the surrounding districts. Groups, organizations, and individuals who answered the plea for assistance in furnishing and equipping the hospital came from many varying religions, races, and interests. Although the new hospital has been in operation since July 28, 1954, donations are still being received.

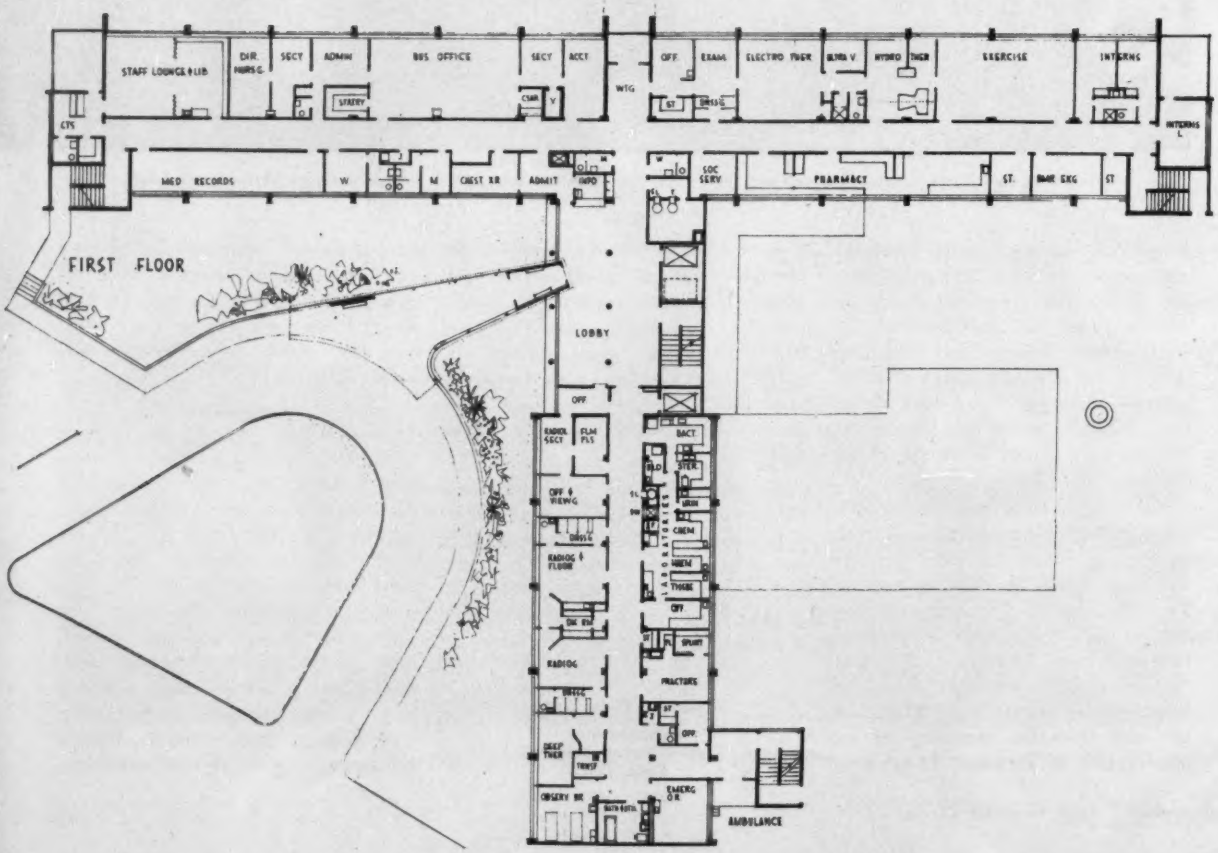
Vera B. Eidt, R.N.,
Administrator,
Trail-Tadanac Hospital,
Trail, B.C.

Construction

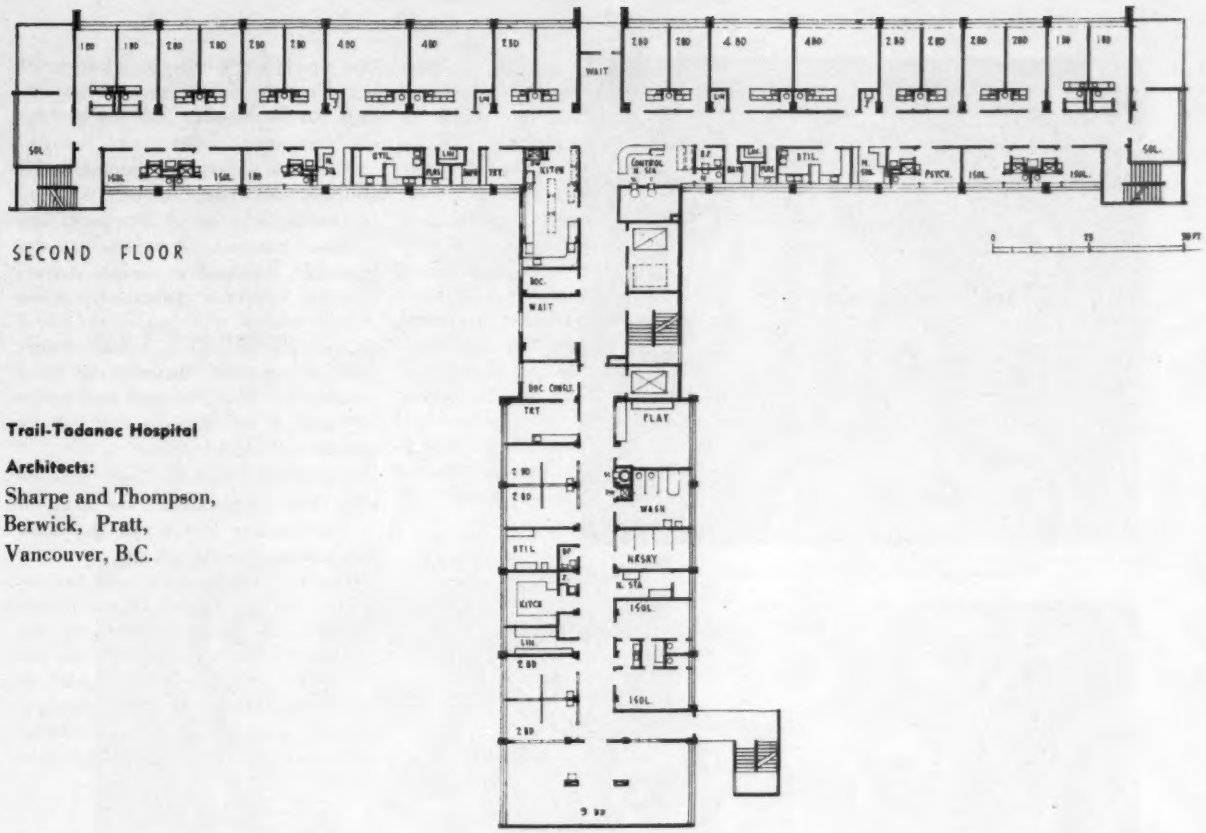
Construction commenced on September 3rd, 1952 and, due to favourable weather conditions, continued throughout the winter months, reaching the half-way mark on August 25th, 1953. On Saturday, July 17th, 1954 the new Trail-Tadanac Hospital was open for public inspection. Since time, patience, and co-operation had been devoted to all phases of planning, details in the new building were given complete consideration and nothing was omitted. During construction, the closest collabora-



BASEMENT FLOOR



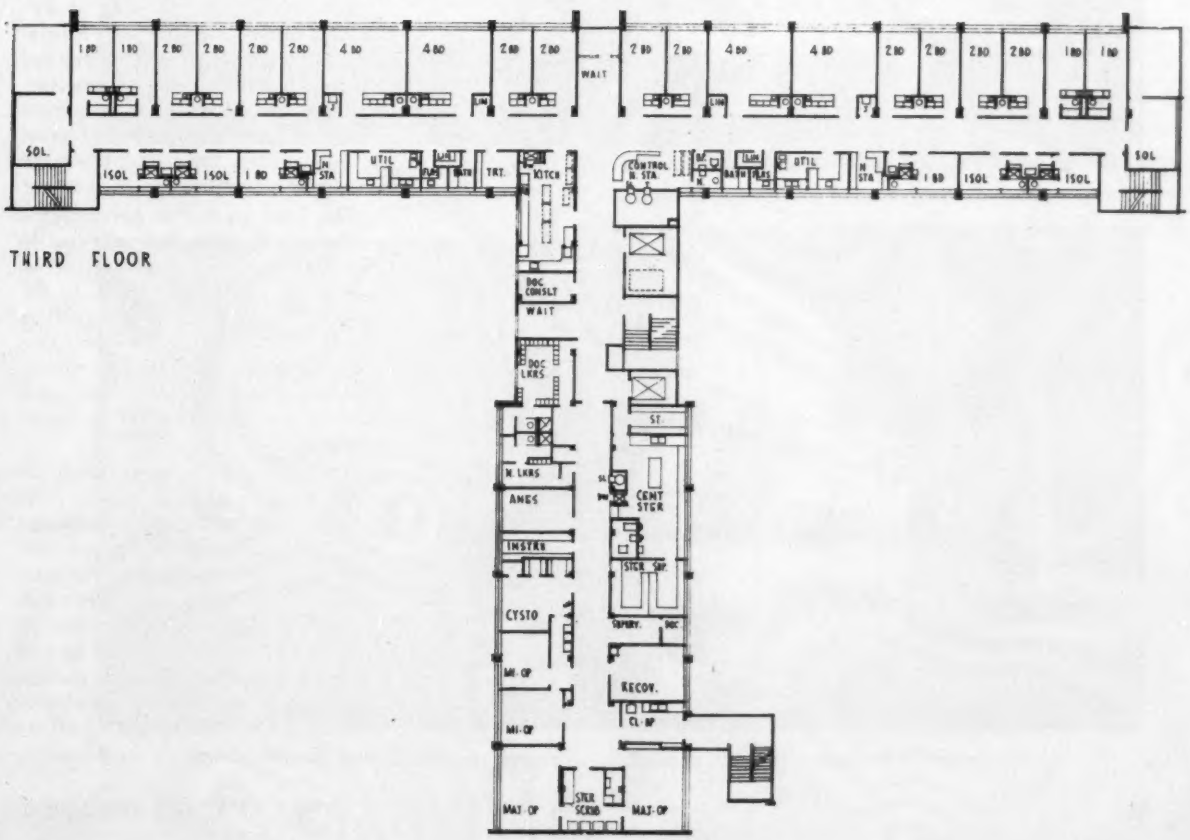
FIRST FLOOR



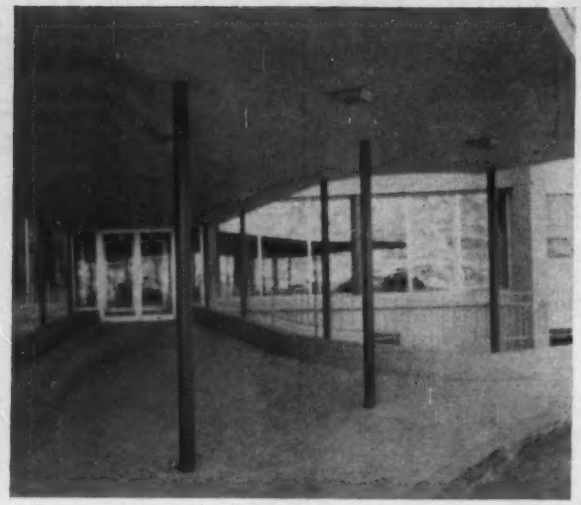
SECOND FLOOR

Trail-Tadanac Hospital

Architects:
Sharpe and Thompson,
Berwick, Pratt,
Vancouver, B.C.

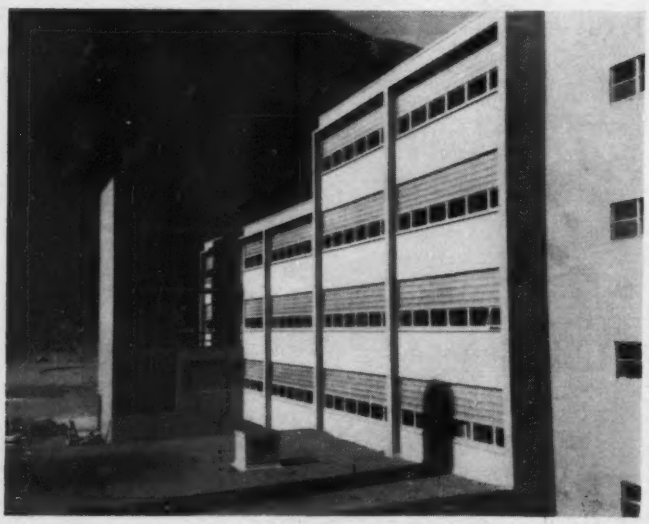


THIRD FLOOR



A close-up of the canopied main entrance.

The main lobby is simple and attractive in design.



The concrete fire escapes are partially enclosed.

tion was evident between the hospital board members, key personnel, architects, medical staff, and the provincial government departments.

The new 150-bed hospital, with facilities for expansion to 225 beds, is the block type of fire-proof reinforced concrete. It is four storeys high and T-shaped in design. An interesting feature of the exterior is the colour scheme of coral, grey, and yellow. The paint is a mastic waterproof compound, sprayed on at a pressure of 100 lbs. and can easily be washed or steam-cleaned. It is guaranteed for 10 years.

Horizontal concrete rows between each floor, "solar slabs", are designed to prevent any direct sunlight from penetrating into the wards.

There is one main entrance for the general public, a separate ambulance entrance, a special entrance for the delivery of goods and one for the use of employees. The main lobby is roomy and attractive, with a canopy-covered entrance which is a distinct advantage during the winter and rainy seasons.

Service Floors

The ground floor or basement area houses the kitchens, cafeteria, coffee shop, central storage with receiver's office, autopsy room, staff locker rooms, central linen, laundry, maintenance, paint shop, boiler plant and offices for the engineer, housekeeper, and dietitian, as well as the oxygen manifold room and garbage disposal area. The latter has refrigeration and sterilization facilities.

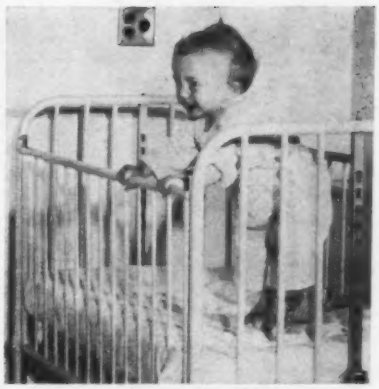
The food service is de-centralized in the new hospital. It is prepared in the main kitchen and then transported in hot food wagons to the ward kitchens on each floor. Here the food is served on plates and then distributed to the patients. Special diet trays are prepared in the main kitchen and sent quickly by dumb-waiter.

The administration area is on the first floor. Various offices are grouped together, with switchboard and information, admitting and routine miniature chest x-ray in near proximity. The doctors' entrance, with in and out register, is located conveniently close to the medical records department and the combined medical staff library and hospital board conference room. Administrative offices and general offices are in this wing.

The physiotherapy department and pharmacy are spacious as are the intern's quarters with sitting room and outside balcony. The pathological laboratory, x-ray, and emergency departments are in a separate wing on this main floor. With the new pathology department, tests can now be made in Trail quickly, instead of sending samples to Vancouver.

Patient Accommodation

Patient accommodation is provided on the second, third, and fourth floors and the bed allocation is as follows: maternity—30 beds and 46 bassinettes; surgery—50 beds; medical—50 beds; and paediatrics—20 beds. The medical patients occupy the second floor where there are separate units for male and female patients, connected by a central nursing station. There is a sub nursing station for each of these units. A separate paediatrics wing is located on this floor. This is a complete unit with its own consultation and treatment rooms, ward kitchen, and waiting areas for parents. The colour scheme is particularly bright and gay and there is an attractive play room. A special feature of the children's ward is a one-way window. It enables the nurse to look into the room but the children cannot look out since the inside of the window resembles a mirror. Bathroom facilities are especially arranged for children, with junior size sinks and toilets.



The children's ward can indeed be a happy place.

On the third floor are the surgical patients, with accommodation arranged for males and females as on the medical floor. In a separate wing are the operating rooms, (two major, three minor) recovery rooms, anaesthetic section, scrub-up area, central supply, and doctors' locker room.

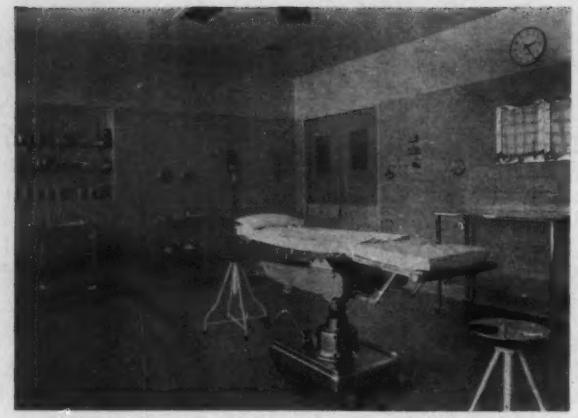
Obstetrical patients occupy the fourth floor. Here, too, are the nurseries and a formula room. The delivery suite is in a separate wing off the main corridor. Provision has been made for premature infants and a separate nursery is provided for segregation and observation purposes.

Patients' rooms consist of: private rooms with bath, telephone, and pillow radio; semi-private rooms (two beds); and public rooms (four beds). All rooms are cheerful in appearance with furnishings and decoration in soft pastel colours. Wall-to-wall windows provide abundant natural light, while artificial lighting is of the indirect type which illuminates but does not disturb the patients. Each bed has a reading light and there is a night light in each room. All rooms and adjoining rooms are equipped with a lavatory of an approved type which provides for the emptying, flushing, and cleaning of bedpans. Each patient has individual equipment and bedpan, with utensil sterilization facilities available in each unit.

A limited number of small single rooms on each floor are designed for the care of infectious and psychiatric cases. A sub-utility room serves each two of these single rooms, in order that careful technique may be observed for isolation cases.

Each floor has a central nursing station at the junction of the corridors.

The doctors' lounge is bright and spacious.



There are two major, three minor operating rooms.

All rooms have a sink, individual built-in wardrobe, mirror and dressing table. There are bedside oxygen and suction outlets strategically placed throughout the patients' rooms, nurseries, delivery rooms, operating suites, recovery rooms and emergency sections. Bed screens are of the stationary type. The patients' signal system is an easily managed non-breakable push button with a flexible cord, accessible to each bed and attached to the wall by a slip join. Signals can be turned off only at the bedside. There are pilot lights located in areas where nurses assemble to work.

Sitting rooms for visitors have been provided, conveniently near the elevators and there are sun rooms for patients at each end of the corridors. An abundance of fresh air and sunshine prevails, all sections of the building being favoured with maximum exposure to sunlight.

Located in the penthouse of the hospital is a complete air conditioning system. All dust particles and impurities are removed from the air as it passes through the conditioner. In addition, the hospital has a specially constructed roof which can be flooded in the summer to keep the whole building cool during the hottest days.

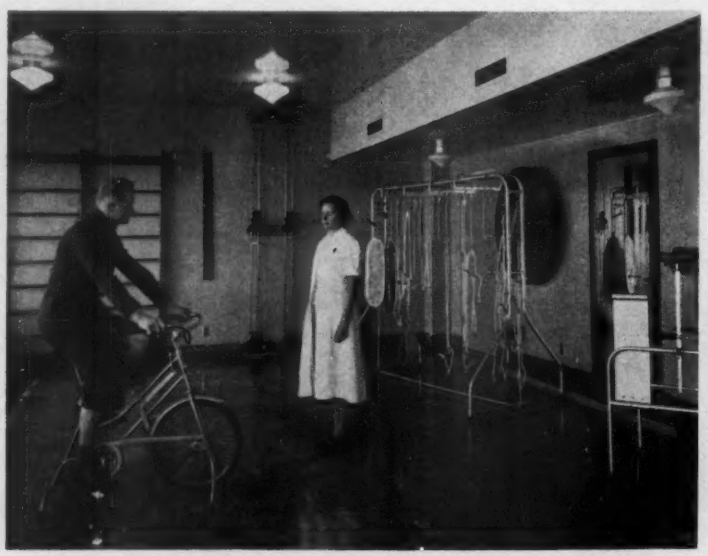
Windows in the wards have double aluminum sash, each in effect a permanent storm window and screen. Corridors have been planned for the purpose they are intended to serve, are straight and of standard width. Angles and sharp curves have been eliminated as far as possible and metal plating has been provided, where necessary, to prevent stretcher and cart damage.

Noise is eliminated as far as possible by means of the hollow clay tile partitions, acoustic tile ceilings and resilient rubber tile floors. In the service area, surgeries, and kitchens, floors are of terrazzo. The conveniently located stairways are approached through swinging doors which also help to deaden noise.

There are two elevators in the building with provision for a third when the need becomes apparent. The fire escapes are of concrete and partially enclosed against adverse weather conditions, thus snow removal is not a problem during winter months.

The hospital is easily accessible to transportation facilities and public utilities. In the event of light and power failure, emergency equipment has been provided. The building is suitably distant from noise, smoke, and odours, and there is proper elevation for good drainage and sanitary measures. Altogether the environment is conducive to the comfort of the patient, with a very pleaant outlook across the Columbia River to the city of Trail and the adjoining municipality of Tadanac. Future expansion has been considered in all planning—facilities have been designed to accommodate 75 additional beds when they are required and there is adequate land available.

Planning and building a new hospital, we have found, is a very satisfactory experience. The people of this community, who have always been enthusiastic supporters, may well be proud of their efforts.



Some of the equipment in the physiotherapy department.

A layman looks at rehabilitation

J. J. Gallagher,
Chairman of the Advisory Board, Montreal Convalescent Hospital, Montreal, P.Q.

FOR YEARS, physical medicine and rehabilitation have been practised. They also have been subjects of study and research, notably in England, but always on a small scale until World War II. During that conflict, the urgent need of restoring the health of certain individuals highly essential to the war effort focused attention on rehabilitation procedures. As cases, two people in England who received wide publicity were the son of Lord Halifax and Wing Commander Bader. In the United States, Dr. Howard Rusk, director, New York University-Bellevue Medical Centre, salvaged a large number of fliers whose return to active service was vastly helpful. Remarkable though progress has been, the findings and techniques which have evolved are serving as a spur to more intensive effort, with more and more possibilities being revealed.

Laymen, with few exceptions, have slight knowledge of what has been going on and practically no perception of potential developments which are going to change our concept of the proper care and treatment for that large portion of our population either temporarily or "permanently" crippled.

This situation is not surprising since very few doctors have been trained in physical medicine and rehabilitation nor, until quite recently, have our universities afforded courses based on the modern formulae for these subjects. Increasing professional knowledge and interest is going to benefit large numbers of patients, who in the future will be directed to specialized institutions for completion of their rehabilitation after treatment for acute illness. Too frequently in the past, they have fallen into the hands of charlatans after preliminary treatment and when that has happened complete rehabilitation became impossible.

Obviously, the foremost consideration in rehabilitation is the physical and mental well-being of the affected person. This is, properly, the responsibility of the medical man—aided, perhaps, by the layman when he provides the facilities for treatment of the patient. Psychiatrists report that following a physical ailment there is always a psychological disturbance, not necessarily in proportion to the gravity of the injury. In some instances, the psychic reaction from a comparatively minor disability is of such magnitude that rehabilitation is not practical.

From purely economic aspects, rehabilitation warrants a great deal more attention than it has been receiving. Lack of rehabilitation affects society generally and governments specifically. The cost of community welfare, as we all know, is increasing to the point where voluntary agencies, dependent on contributions from the public, are beginning to see the end of the financial road. When they reach it, governments, at all levels, will have an infinitely greater social problem than that with which they are now wrestling.

Positive Aspects of Rehabilitation

Rehabilitation contributes a cheerful note. Its objective, achieved in a majority of cases, is to move the individual out of the ranks of those dependent on "charity" by enabling him to become self-supporting. It requires little imagination to visualize the economics involved in changing 5,000 "recipients" in to 5,000 "earners", thus resulting in great savings to governments, social agencies, and taxpayers. And one may multiply the savings made in one year by the 10, 20, or 40 years which may be the life expectancy of the individual who has been rehabilitated. Over a period of years, such savings mount to a staggering total of millions of dollars. Nor can we overlook the economic advantage of rehabilitating even a millionaire. His rehabilitation may be essential to the successful operation of a business employing thousands of workers. In the same way, consider the value of rehabilitation in Workmen's Compensation cases. The patient is returned to work more quickly, compensation cheques are fewer, and pension payments are reduced—all of which have a bearing on the total amount industry must pay into Workmen's Compensation Commissions every year. Rehabilitation goes far beyond the point of liquidating its own cost and pays colossal dividends in the savings it makes possible.

Paralleling the laymen's lack of knowledge of what is being done in rehabilitation is his misconception of hospitalization as it applies to physical medicine and rehabilitation. The average citizen reasons that incapacitated persons require hospital care—that implies providing hospitals. Hospitals cost so many thousands of dollars per bed. Citizens and governments contribute the money and the patient is taken care of at a cost, inevitably high.

Rehabilitation hospitals cannot be measured and judged by the financial and operating standards of general hospitals. In view of end results, cost cannot be considered on the normal "per bed" basis. In a fairly large rehabilitation centre, only a relatively small number of dormitory-type beds is required. These beds do not have to support indispensible but costly operating rooms, x-ray departments, laundries, pharmacies, and other essential services such as are found in acute general hospitals.

Actually, rehabilitation aims to take the patient out of bed by restoring the impaired physical conditions that made him a bed patient in the first place. This is rehabilitation's attitude towards those hundreds of admissions who come from other hospitals where they have been occupying costly beds which are urgently required for acute cases.

The basic requirement in general hospitals is beds, although out-patient services, too, are vital. The situation is reversed in the rehabilitation hospital where emphasis is placed on out-door clinics and prescribed rehabilitation procedures which apply to both in-patients and out-patients. The ratio, however, in the rehabilitation hospital is four out-patients to one bed case. This fact is important

(Concluded on page 72)

Mr. Gallagher is a member of the board of directors of the Rehabilitation Institute of Montreal and a past-president of St. Mary's Hospital, Montreal.

Hospital Statistics—

Yardsticks in determining progress

B. R. Blishen, M.A.,
Chief, Institutions Section, Dominion Bureau of Statistics, Ottawa, Ont.

IN THE field of hospital care, the past 20 years have seen a great expansion in patient volume and a great improvement in the quality of hospital services. At the same time, significant changes have occurred in the conditions which keep people in hospital. The infective and contagious diseases have declined in importance, while chronic and disabling conditions have come to the fore as major public health problems. These changes have all been reflected in the complexity of hospital administration.

During the same period, and particularly since World War 11, hospital costs have increased to the extent that voluntary groups and municipalities can no longer shoulder the financial burden of running our hospitals alone. As a result, both provincial and federal governments have become more deeply involved in the problem of hospital financing.

There are a number of factors which have contributed to the serious increase in hospital costs, but I shall mention only a few. The first is the factor of inflation. Using as a base the period 1935 to 1939 equalling 100, it can be shown that, due to inflation, the gross national expenditure dollar in 1939 was worth $2.01 in 1953. In other words to-day's dollar would have been worth around 50 cents in 1939.

Another factor which we must take into consideration is the increase in population and its effect on the increase in hospital admissions. Between 1931 and 1951 Canada's population increased 35 per cent. During the same period admissions to public hospitals increased 240 per cent. To be more precise the number of admissions per bed increased from 13 in 1932 to 26 in 1952. In other words it doubled. This is partly due to a greater awareness on the part of the public of curative and preventative powers of modern medicine and the ability to pay for hospital care through prepayment plans such as Blue Cross. During the same period, the rate of admissions per 100,000 population increased from 5,190 to 12,536.

It is quite clear that, in order to understand these complex problems properly, statistics of the highest quality are necessary. This understanding can then lead to proper planning and action by the various levels of government and the hospitals themselves.

Estimating Need for Beds

I shall now mention briefly and in general terms the manner in which the information, which is collected from hospitals, is used for this purpose by governments. Take, for example, the rated capacity of the hospital according to the various types of beds. As you know, both federal and provincial governments have spent large sums of money in hospital construction grants; and they must know how this has affected the number of beds available to the population according to prescribed standards of space. With these standard capacity figures, governments are able to measure the extent to which building is keeping pace with population growth. Thus, the ratio of beds set up to bed capacity will indicate the degree of overcrowding. For example, if we show that 15,000 medical beds are set up in space which according to standard capacity figures should hold only 12,000 beds, we know the degree of overcrowding. Furthermore, when we break these figures down according to the size, type, and ownership of hospitals within the provinces, they become even more significant.

The statistics on patient movement are very important for government planning. Take for instance the figures on admissions. We can relate the trend in admissions to the population and arrive at the rate of admissions for every 100,000 of the population. Since we have reliable population estimates of the future we can, within limits, apply our admission rate to the future population and arrive at an estimate of future bed needs. As you can see, this is extremely valuable information to government hospital authorities who must keep abreast of the bed needs of the population.

Personnel

Let us now turn to questions on personnel and hours of work which seem to be the nemesis of so many hospital administrators when they try to report these figures to us. I shall not discuss the statistics concerning all the various categories of personnel, except to say that it is self-evident that provincial authorities responsible for seeing that hospitals are efficiently operated must know if the number of personnel is adequate. However, I would like to say a few words about our figures concerning graduate nurses working in hospitals. A great deal has been said about the nursing shortage; but if this shortage exists and is to be overcome surely it is vital to know the capacity of our schools of nursing. These figures are reported to us and are available. The claim has been made that if the graduate nurse spent her time nursing, the shortage of such personnel would either disappear or be greatly reduced. The figures on hours of work which you report to us are tabulated and published in such a way that one can see the departments in which the nurses spend their time.

Government Aid

I have already indicated that federal and provincial governments are shouldering an increasing proportion of hospital costs, and it is their responsibility to determine how their outlays are affecting hospital financial operations. For example, what proportion of revenue is received from governments in terms of grants or for special types of patients; and what proportion

(Continued on page 82)

An address presented at the Ontario Accounting Institute, Toronto, Feb., 1955.

● *1,000,000 NEWSWEEK families* will better appreciate the Radiologist *as a physician* after reading this message in the *April 11* issue. Reprints of each advertisement in this series are available.

death took a holiday...

grandma is alive and lively! It's one of those happy facts that probably couldn't have happened a generation ago. For you see, grandma had *cancer*.

It was only 5 years ago — after one of her annual physical check-ups — that the family doctor told her what the radiologist and pathologist had detected.

Being an old-fashioned lady, grandma felt sure her time was up. Being a brave lady, she was prepared to go without fuss.

So naturally, she was surprised when the doctor said there was an excellent chance of arresting the malignancy. He thought it had been caught in time.

First came the operation. Then the radiologist attacked the cancer with a carefully planned sequence of x-ray treatments. Even an x-ray physicist worked with grandma. He helped the radiologist in plotting the treatments for best effect.

The battle was won. Grandma feels and looks fine. Death took a holiday.

First diagnosis . . . then treatment. Both depend heavily upon x-ray . . . both call for knowledge on the part of the radiologist developed through years of training and experience. To help the medical profession broaden its effectiveness, General Electric will continue to provide ever-improving x-ray apparatus.

Progress Is Our Most Important Product

GENERAL ELECTRIC

Industry, too, relies on General Electric X-Ray for non-destructive testing and inspection equipment

We modified our special diet kitchen

Sister Mary Loyola,
Therapeutic Dietitian,
Halifax Infirmary,
Halifax, N.S.

IN OUR hospital, as in many others, the diet kitchen was remote from the main kitchen. The two could be considered, in most particulars, as separate departments. Some foods sent out from the diet kitchen were first prepared in the main kitchen; more were prepared in the diet kitchen. There was, in many cases, unnecessary duplication of food preparation with resultant food waste. The additional food preparation, the constant traveling back and forth to the main kitchen, bakeroom, storerooms, and refrigerators consumed extra time on the part of all diet kitchen personnel. As a consequence, those involved had less time to devote to personalized patient relations and scientific advancement.

Accompanying the division of the diet kitchen from the main kitchen were other problems:

(a) The spaces allocated to dining room area for employees were no longer large enough nor suitable in their very close proximity to the main kitchen;

(b) The office adjoining the diet kitchen did not possess adequate capacity to accommodate two dietitians' desks, book cases, files and chairs;

(c) The student nurses assigned to diet kitchen duty spent most of their time carrying out the multitude of practical diet kitchen services, to the detriment of learning diet therapy chiefly through clinical teaching.

Minor snags in efficient dietary management were becoming evident. To mention a few:

From the diet kitchen came all salads which were served in the hospital. This alone was a time-consuming task, since it meant approximately 80 daily for special orders alone, or an estimate of 200 daily if salads were served to every patient. Thus the preparation, setting-up, and sending of salads to the various floors, *via* dumbwaiters was performed by the diet kitchen staff.

Special diet trays sent from the diet kitchen to the floors were set up and served from this unit. Some of the food had to be delivered or collected from the main kitchen, and then weighed for the various diets. Although these trays were routinely served, checked and sent to the floors by means of the dumbwaiters within a maximum of three minutes, they were not always removed promptly thus giving patients cause for complaint about lukewarm food.

The diet kitchen personnel was responsible also for filling the daily requisitions from the floors for breakfast supplies (juices, fruits, jams, et cetera); soft desserts (baked custards, blanc manges, gelatin desserts, junkets, et cetera); fruit desserts (baked apples, fruit cups, stewed and pureed fruits, et cetera); vegetables (baked stuffed potatoes, plain baked); special diet preparations (scraped beef, ground meat, pureed fruits and vegetables, low sodium foods, restricted carbohydrate or high protein desserts, tube and supplementary feedings); and any orders not on the general menu (omelets, souffles, creamed or scalloped dishes, chowders, beef tea, gruels, et cetera).

In addition to the above, the following responsibilities fell to the diet kitchen: supervision of guest trays, meals for sick staff members, catering for various staff, nursing school and alumnae functions.

Making Two Into One

As is now obvious to the reader, two kitchens were being operated where one might very well suffice. By job analysis, it was decided what could be done more logically in other departments, namely the main kitchen, bakeroom and storeroom. With careful planning, special diets could correspond closely with the general menu. Food could be prepared at the initial stage of cookery (bland, fat free or low sodium) from the general foods.

A major change was suggested for special diets. Special diet trays would no longer be sent from the diet kitchen but from each floor. The previous evening, diet slips were delivered to the serveries. Foods, on these slips, not on the general menu, were ordered from the various departments the next day. Prior to tray delivery, servery maids, previously instructed, placed the cold orders on the trays. Hot foods were served by the person in charge of the servery, checked as to quantity by the dietitian on the floor, and carried to the patient by the nurse on duty in the diet kitchen.

The diet kitchen, now streamlined as to practical work, had no further need of spacious quarters or elaborate equipment. The removal of large steam tables, tray racks, dish cabinets, and tables gave an area larger than expected which immediately proved itself ideal for dining room services. It was away from the kitchen, next to staff dining rooms, well-lighted, and overlooked the attractive courtyard. Freshly painted walls, cafeteria tables, done in contrasting colours, colourful drapes, plants and pictures produced a dining room which gave a feeling of serenity and a boost to the morale of the employees.

The smooth running of this cafeteria-style dining room for both men and women is due in part to the dietetic interns' supervision as they rotate in this area as part of their training in dining room supervision.

The adjoining office likewise underwent complete renovation and provided a pleasant, convenient-sized reception dining room for four or six transient guests.

A New Work Area

The men's dining room, which was formerly too near the main kitchen for the desired meal-time "comfort", was the logical and ideal spot for a

(Concluded on page 90)

Food Service

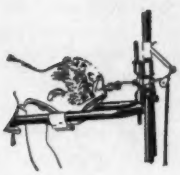
sponsored by the

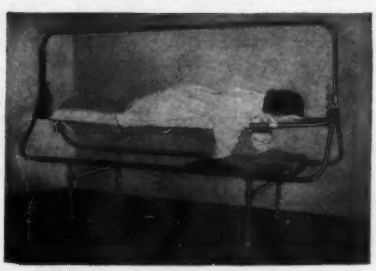
Canadian Dietetic Association

Stryker Turning Frames

For uniform skeletal and head traction . . . complete immobilization

. . . easy, safe patient handling by one nurse





No fracture disturbance is necessary in the care of patients on the Stryker Turning Frame. If operative fusion to maintain reduction is indicated, the operation may be done on the frame in either posterior or prone position with traction continued at all times. One nurse can turn the largest patient on this frame with ease.

The Stryker Turning Frame is essential for the effective care of immobilized patients. Nursing for cervical fractures, burn cases, paraplegics and patients under continuous traction is quick, easy, without patient disturbance. Treatment of back wounds and burns as well as bedpan service is simpler. Bed sores and the dangers of kidney and bladder stones are largely eliminated.

AVAILABLE THROUGH LEADING CANADIAN SURGICAL SUPPLY HOUSES ACROSS CANADA

Canadian Agents: **Fisher & Burpe Limited**

Provincial Notes

Prince Edward Island

SUMMERSIDE. A new x-ray machine has been installed at the Prince County Hospital. The cost of the machine was around $12,000.

Nova Scotia

GLACE BAY. Fire broke out in the penthouse of the tuberculosis unit of the Glace Bay General Hospital last February. All patients filed to safety through the tunnel into the general hospital. Of the 34 patients, only two were stretcher cases.

* * *

NEW GLASCOW. The new Aberdeen Hospital was officially opened last month. It contains 238 beds and 39 bassinets and replaces a 143-bed hospital which was founded in 1897. The architect for the new hospital is E. J. Turcotte, Montreal.

New Brunswick

NEWCASTLE. At the annual meeting of the board of trustees of the Miramichi Hospital, it was reported that the hospital had received a capital gift of $10,000 from Lord Beaverbrook, as well as other capital gifts amounting to $4,000.

Quebec

MONTREAL. It is expected that the $20,000,000 Montreal General Hospital will be ready for occupancy in May. Patients from the western division are scheduled to move into the new building during the week beginning May 22nd and central division patients will be moved the week beginning May 29th. An estimated 5,322,000 pieces of brick and masonry block have been used in the 19-storey building and there are 280 miles of wire, 14,000 light bulbs, and 5,000 light switches. The new hospital will have approximately 750 beds, over 100 more than its present western and central divisions combined.

Ontario

CARLETON PLACE. The new Carleton place and District Memorial Hospital was opened by Hon. Paul Martin, Minister of National Health and Welfare, in February. The first hospital to be built in this town of 5,000, the institution contains 36 beds and 10 bassinets. The building cost $304,000 for construction and architects' fees and $96,000 were spent on equipment and furnishings. The architects were Drever and Smith of Kingston.

* * *

NEWMARKET. Construction has commenced on the new 52-bed wing to the York County Hospital. The contract has been let for approximately $509,000.

* * *

PARIS. At the 33rd annual meeting of the board of governors of the 60-bed Willett Hospital, it was reported that the hospital had ended 1954 with an operating surplus of $8,564.41. The actual surplus before depreciation, determined by subtracting bad debts of $2,240.52 and adding donations totalling $1,054.92, was $7,279.81. Depreciation on building and equipment was $7,347.48, bringing the final figure to a net deficit of $67.67. Cost per patient day was $8.01 and revenue, $8.70.

* * *

TORONTO. The first sod has been turned for the new Branson Hospital which is being built on Bathurst St. at Finch Ave., by the Seventh Day Adventist Church. It is being built in three stages and will begin operations when the first 50-bed unit is completed.

Manitoba

SELKIRK. The old Selkirk General Hospital which served that town for 49 years has been replaced by a new 65-bed structure which was built at a cost of $500,000. A two-storey nurses residence has also been erected on the grounds. On the occasion of the formal opening of the hospital, a memorial plaque was presented by the Manitoba Pool Elevators.

* * *

TEULON. A new 20-bed hospital, built at a cost of $165,000, has been formally opened at Teulon, replacing a 50-year old structure administered by the United Church women's auxiliary. The concrete block one-storey building was designed by architects Waisman and Ross of Winnipeg.

Saskatchewan

MOOSOMIN. The Saskatchewan department of public health has approved a grant of $25,000 to Moosomin Union Hospital to assist in the construction of a new 20-bed addition to the hospital. Improved surgical and obstetrical services will also be provided.

* * *

SASKATOON. The first phase of the more than $2,000,000 modernization plan at Saskatoon City Hospital, *i.e.* construction of a new centre block, is almost completed. The second phase which involves demolition of the old centre block and extensive construction to connect the new block with the existing wings will begin this spring. The program will require an estimated two years for completion. Frank J. Martin, local architect, collaborated with Govan, Ferguson, Lindsay, Kaminker, Langley and Keenleyside, of Toronto, in drawing up the plans.

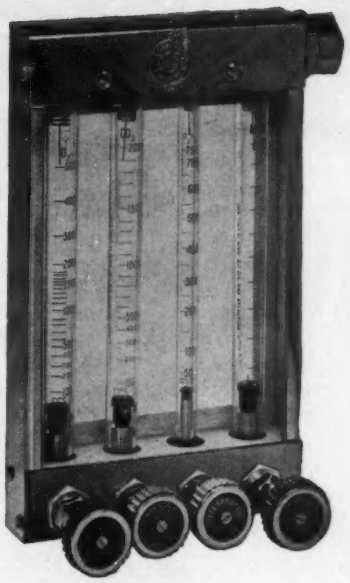
Alberta

LETHBRIDGE. St. Michael's Hospital has established the rooming-in system for mothers and babies with the purchase of 16 special bassinettes for this purpose. Glass panelled cribs can be moved aside to make space for bathing the baby, while all the necessary equipment is contained in a cupboard below.

British Columbia

DUNCAN. At a meeting of the Board of Trustees of the King's Daughters' Hospital early this year, it was reported that the average hospital occupancy for last year had been 90 per cent and at times over 100 per

(Concluded on page 72)



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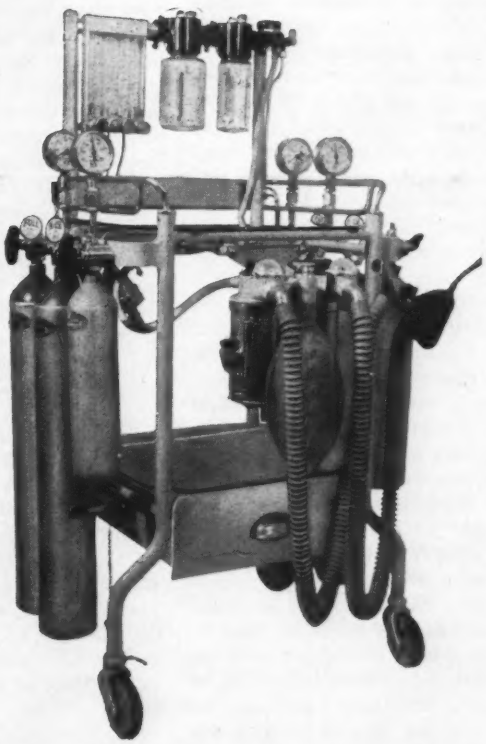

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Here and There

Story of Guy's Hospital Stresses Role of Voluntary Staff

(The following excerpts are taken from the introduction to "Mr. Guy's Hospital" in London, England, by H. C. Cameron, M.D., F.R.C.P., published by Longmans, Green and Co., London, New York, and Toronto.)

The story of such a hospital as Guy's makes it very plain that the strength of the voluntary system, to a great extent, lay in its power to attract men of ability and influence to the conduct of its affairs. Almost to the last a determined treasurer seldom failed to gain his end from lack of financial support.

Of equal importance in every hospital was the contribution of the staff. It was unpaid, although at Guy's the holders of those posts which dated back to the early years of the hospital still received annually the little sum which had once been a payment adequate in amount. Nevertheless, the indirect value of the appointment to the holder was very great. If it did not ensure for him success in practice, it was a preliminary almost essential to that success. In the reign of Queen Victoria a treasurer of Guy's is said to have declared that the market price of a vacancy at his hospital might well be five thousand pounds . . .

That the members of the staff were not paid, did not lead to slackness or irregularity in the performance of their duties. Every voluntary hospital when its story is told will be found to have owed an enormous debt to the labours of its voluntary staff. Often they were not content only to carry out their allotted tasks; they were active in enlisting support for their hospital and at times it was by their successful efforts to secure the necessary funds that extension and development were achieved. Their own needs and the needs of their hospital were the one and the same. If their work there was to prosper and bear fruit, everything must be provided. Of some of them it is true to say that they were not only the efficient servants of their hospital, they were themselves the architects of its greatness. If wealth or influence came to them because of their appointment, they repaid the debt and used it for the benefit of their hospital and school.

International Hospital Federation Arranges Hospital Visits for Members

An important function of the Secretariat of the International Hospital Federation is that of arranging for members to visit hospitals in other countries and of advising them on the most interesting hospitals for their particular purpose. During the past few months, members from Australia, South Africa, Great Britain, the Netherlands, Jamaica, and the U.S.A., have made extensive use of the Federation's services in drawing up a program of hospital visits in various countries. During these tours, hospitals were visited in Belgium, Canada, Denmark, Finland, France, Great Britain, Italy, the Netherlands, Sweden, Switzerland, and the U.S.A. In all cases, the Federation provided letters of introduction to the hospital authorities concerned and, wherever possible, made appointments for the visitors in advance.

Anglo-U.S. Hospital in Madrid

A 21-bed Anglo-U.S. hospital was opened recently in Madrid, Spain. The building costs of £80,000 have been met by private contributions raised in Britain, the United States, and Spain. The nursing staff is British, assisted by Spanish nurses, and an English-speaking doctor is available. Provided there is accommodation, the hospital will be open to patients of all nationalities.

King's Fund Projects

Two new hospital developments which owe their being to gifts from the King Edward Hospital Fund have been completed recently. Highwood House in North-West London, Eng., has been purchased as a Red Cross home for patients from the Central Middlesex geriatric unit; and a contribution made toward a new recreation hall for the Fairlight Sanatorium, Ore.—*"The Hospital", Feb. 1955.*

French hospitality . . . c'est magnifique!

Participants in the study tour of French hospitals, sponsored by the International Hospital Federation last May, were given a gallic welcome. As noted in the *Report of the Study Tour of Hospitals in France*: "The warmth of welcome everywhere both by civic and hospital authorities, and the generous hospitality offered, left nothing to be desired . . . The French believe that good food and wine should not be spoilt by hurried eating and, as a result, some of the luncheons lasted up to two hours."

In the hospitals, the food served was also good. "It was well prepared and cooked and attractively served, even in old hospitals where conditions might have led one to expect inferior service. Many of the excellent lunches taken by participants were prepared in the kitchens of the hospitals visited. Many patients were spoken to on the subject of food and not one complaint was heard. Food stores are well arranged and supervised; they present a very clean and orderly appearance."

New Hospital being built in Malaya

Construction is proceeding on the Lady Templer Tuberculosis Hospital in Kuala Lumpur, Malaya. When finished, the hospital will accommodate 140 patients and it is expected to be in operation by midsummer.

"Mr. WHO" Comes to Thailand

An Indian doctor working on malaria control in a remote village in northern Thailand asked the local headman a few questions: Had he heard of Mr. Nehru? "No" was the answer. Had he heard of President Eisenhower? "No." Had he heard of the UN? Again, "No." Had he heard of WHO? "Oh, yes" the man replied, Mr. WHO is the man who sprayed my house and we have had no more sick babies — a very good man". — *David McK. Key in Public Health Reports, February, 1955.*

Every man takes the limits of his own field of vision for the limits of the world. — *Arthur Schopenhauer*

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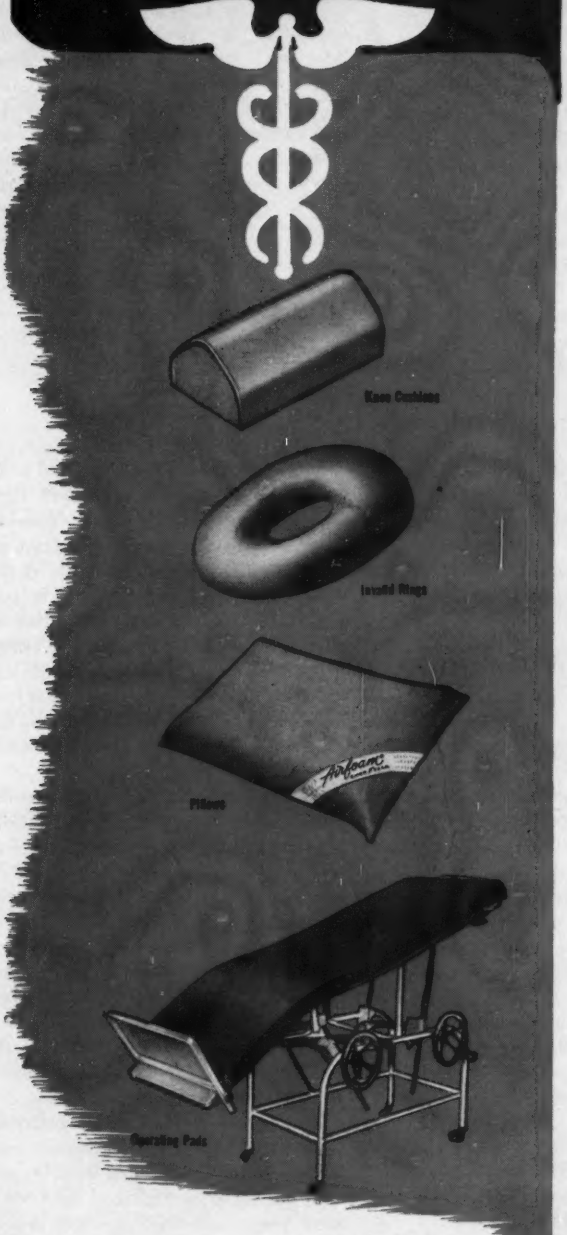

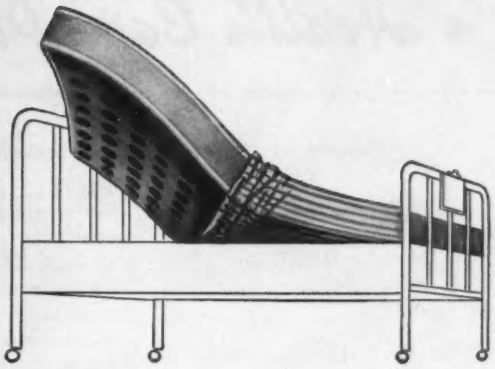

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◂ Health Care Plans ▸

Volume of Hospital Care in Saskatchewan

(The Saskatchewan Hospital Services Plan, completed eight years of operation on December 31st, 1954. The following information is from the 1954 annual report.)

In 1954, the Saskatchewan Hospital Services Plan accepted financial responsibility for the hospital accounts of 165,127 discharged patients other than newborns—a slight decrease from the 1953 total of 165,410. Total patient days covered by the Plan also dropped, 1954 being the third successive year in which such a decline has been recorded.

Newborn cases covered by the Plan have increased every year since 1950, totalling 22,767 in 1954. As over 96 per cent of all Saskatchewan births take place in hospital, and since the Plan covers nearly all of these cases, the number of newborn accounts for which the Plan accepts responsibility is determined to a large extent by the birth rate.

Average days of stay for discharged cases, other than newborns, ranged from 10 days in 1947 to a high of 11.1 in 1951. The average length of stay has shown a tendency to decline since that year, dropping to 10.6 days in 1952 to 10.4 days in 1953, and 10.2 days in 1954. For newborn cases, the average stay per case has shown a steady downward trend for several years—a high of 9.2 days being recorded in 1947 and a low of 7.6 days in 1954.

The number of long-stay cases occupying beds at December 31st, had declined for the second successive year. There were only 34 cases in hospital at the end of 1954 who had been continuously hospitalized for more than one year, as compared to 67 cases at the end of 1953 and 101 cases at the end of 1952.

This change may be attributed in large measure to an alteration, early in 1953, in the policy of payment for hospital accommodation of long-stay cases. Prior to that time, when active hospital care was not required by a patient, the Plan's payments were not discontinued unless alternative accommodation was available. Since April 30th, 1953, the question of alternative accommodation for persons requiring only custodial care has not been considered a decisive factor. Payments by the Plan are ordinarily discontinued after the attending physician has indicated that hospital care is no longer necessary. The application of this policy, which tends to make a greater proportion of general beds available for acutely ill cases, has been facilitated by the opening of additional nursing home accommodation in the province within the past year.

Hospitalization rates have followed the same trend as the total volume of hospital care. The number of discharged cases per 1,000 covered population rose from 156 in 1947 to 200 in 1949. Since that year, the rate has ranged between 199 cases per 1,000 and 206 cases per 1,000. In 1954, the Plan experienced a rate of 204 hospital cases per 1,000. Patient day rates also rose rapidly after 1947, then levelled off in 1950. Since 1951, the number of days of care per 1,000 has dropped slightly with each succeeding year. In 1954, the Plan experienced 2,084 days of care per 1,000 persons compared to a rate of 2,201 days in 1951.

Since the inception of the Plan, nearly all hospital care received by beneficiaries has been provided in Saskatchewan institutions, with only a small percentage of patients being hospitalized outside the province. Out-of-province hospitalization in 1954 accounted for 2.5 per cent of cases of adults and children and 2.2 per cent of new born cases.

* * * *

New Executive Director of Blue Shield Commission

The appointment of John W. Castellucci as executive director of the Blue Shield Commission, Chicago, Ill., has been announced by Dr. L. Howard Schriver, president of the Blue Shield Commission.

Mr. Castellucci, formerly assistant director of the Michigan Medical Service, has been with Blue Shield since 1943. He succeeds Frank E. Smith and has been serving as acting-director since Mr. Smith's resignation.

* * * *

Appointment at Blue Cross Commission

Artemas C. Leslie, who for the past five years has been insurance commissioner of Pennsylvania, has been appointed associate director of the Blue Cross Commission. He is in charge of a newly established office in Washington, D.C. and assumed his new duties, mainly those of federal government relationships, on March 1st.

* * * *

Currently, over 46 million North Americans, including more than 3,200,000 Canadians, participate in Blue Cross hospital care protection.

Voluntary Service by Hospital Trustees

The question may well be asked as to why so many of the competent men and women of our country provide volunteer service to our hospitals as members of boards of trustees. A desire to help our fellow man is one reason and the personal satisfaction of participating in a community enterprise is another. The most significant reason, however, is possibly the thinking that volunteer endeavour is the basis of initiative and our free democratic way of life.

With present-day high costs and the complexities of hospital administration, it would be easy for hospital trustees to give up the operation of our hospitals and allow government to take over the complete control. Should this thinking become a reality, whereby the state is responsible for the health and welfare of people from the cradle to the grave, there is serious risk of public apathy, a shelving of responsibility and a leaning upon government. When a matter becomes the business of the state, the community proves lax to its responsibilities and when the area extends over the whole field of human welfare, private initiative is stultified and what were previously privileges are looked upon as rights. Ultimately this becomes a surrender of freedom, which in itself is a denial of democracy. This, then, is possibly the main reason why the leaders of our community are happy to devote volunteer time and serve as hospital trustees—*Douglas Peart, Ottawa Civic Hospital.*

With the Auxiliaries

Auxiliary Helps Mentally Ill

A new phase of hospital auxiliary work is that connected with mental hospitals. This phase has been pioneered in Ontario by Mrs. D. O. Lynch, formerly of Kingston, now of Toronto. Mrs. Lynch is a member of the Women's Hospital Auxiliaries Association, Province of Ontario.

Four years ago, Mrs. Lynch, the wife of a Kingston doctor prominent in the mental health field, saw the possibilities of a women's auxiliary to a mental hospital. With vision and courage, she founded and became first president of Rockwood Women's Auxiliary to the Ontario Hospital for the Mentally Ill, Kingston.

We say courage advisedly because there were many obstacles to overcome —the indifference of the general public, the unwillingness on the part of patients' relatives to have outsiders going into the hospital, and the timidity of the patients in participating in social events arranged for them.

However, the auxiliary went ahead and undertook various projects such as teas, musicals, ward visits, and special events. All of these helped to overcome the patients' timidity and helped to make them feel part of the outside world.

The interest of the auxiliary members in the patients in a mental hospital has done a great deal to encourage a more enlightened public attitude toward mental illness. Proof of this lies in the fact that the auxiliary has grown from its 15 charter members to its present enrolment of 104.

Enquiries concerning the work of this auxiliary have been received from many provinces and Mrs. Lynch feels sure that Rockwood Auxiliary will be followed by many others.

—Dudley Buchan.

* * * *

Auxiliary to Perth Hospital Reports

With a membership of 387, the Women's Hospital Aids Association of The Great War Memorial Hospital, Perth, Ont., has completed a very successful year. From the treasurer's report, members learned that the total receipts for the year totalled over $6,000. Through the sale of dime cards, the sum of $221 was realized, while the tea held on National Hospital Day brought in $300. The annual bazaar, held in September, netted the auxiliary nearly $2,200 and a very enjoyable supper bridge, held in January, brought in $222. The sewing committee completed 336 articles and mended hospital linen.

Nearly 126 items were made for the show case of hand-made articles which the auxiliary operates in the hospital. Sales of show case articles resulted in $136. Another successful project was a concert which raised $55.

The auxiliary used some of this money to purchase linens for the hospital, an expenditure of $1,159.37. They also purchased equipment such as two electric kettles, a new stretcher for the operating room, a croupette for the nursery, and two electric stoves for the diet kitchen, as well as seven bed-side lamps for the nurses' residence.—*Mrs. E. M. Sabiston.*

* * * *

48 Years in Hospital Work —and Still Active

When the first sod was turned recently for the new wing of the Belleville General Hospital, Belleville, Ont., the ceremony was performed by the immediate past-president of the Women's Hospital Auxiliaries Association, Province of Ontario—Mrs. W. C. Mikel of Belleville.

Mrs. W. C. Mikel

Mrs. Mikel has an enviable record of service to hospitals and hospital auxiliaries. Her association with the Belleville General Hospital dates back to 1907 when she joined the Women's Christian Association, which at that time operated the hospital. She was president of this association from 1917 to 1928 and was a director of the Ontario Hospital Association from 1939 to 1949.

Now honorary president of the Belleville Hospital Auxiliary, she is also a charter member of that organization. She is a member of the board of governors of the Belleville hospital and in length of service has the longest record of any on the board. She takes a keen and active interest in her own auxiliary and also in provincial affairs.

—Dudley Buchan.

* * * *

News of Quebec Auxiliaries

Mrs. J. Cecil McDougall, Montreal, president of the Province of Quebec Association of Hospital Auxiliaries, reported that the organization now includes 30 groups with a combined membership of 16,500. The auxiliary to the Jewish General Hospital in Montreal has shown a remarkable ability to obtain members. Only two months after its membership drive was organized, 1,850 volunteers had joined the group.

* * * *

Portage la Prairie Auxiliary Aided by Rural Guilds

During 1954, the auxiliary to the Portage la Prairie General Hospital, Portage la Prairie, Man., spent $3,333.98 on various hospital projects. A number of rural guilds contribute their efforts to the work of the auxiliary by providing preserves and jelly, purchasing equipment, as well as sewing and mending linen.

* * * *

Woodstock Auxiliary to Equip Nursery

The auxiliary to the Woodstock General Hospital, Woodstock, Ont., reported at its annual meeting that the Special Fund, which has been built up over the past few years, was increased by $1,500 during 1954. A new project for the group is the purchase of 15 nursery cubicles which will cost about $3,200.

(Concluded on page 60)

Annual Report of Auxiliary to Alexandra Hospital, Ingersoll, Ont.

At the annual meeting of the auxiliary to the Alexandra Hospital in Ingersoll, Ont., it was reported that $1,426.67 had been spent in hospital purchases during 1954. Some of the items included: a cardex file, filing cabinet, diathermy unit, bed rails, and bookcases. The sewing committee spent 176 hours mending 749 articles and made 319 new ones. The gift shop made about $350 which will be used towards installing an inter-communication system in the hospital. Money was raised through many activities such as a Florence Nightingale Tea ($390.84); a Rose Tag Day ($714.88); and a penny sale ($619.21).

* * * *

Auxiliary to Hotel Dieu in Windsor Raised $4,355 during the past year

At the annual meeting of the auxiliary to the Hotel Dieu of St. Joseph in Windsor, it was reported that a total of $4,355 had been raised during 1954. A cheque for $1,500 was presented to the hospital last December to complete payment on nursery cubicles. The auxiliary also bought three wheel chairs and presented each nursing graduate with a gift. The group has a membership of 112, with 20 life and honorary members; 25 new volunteers were welcomed last year.

* * * *

Orillia Auxiliary to Purchase Electrical Equipment for Nurses' Home

Among projects of the auxiliary to the Orillia Soldiers' Memorial Hospital, Orillia, Ont., is the purchase of electrical equipment for the nurses' residence. One of last year's purchases was a steam jacket kettle; the kettle and its installations amounted to $860.

* * * *

Successful Year for Dunnville Auxiliary

The auxiliary to the Haldimand War Memorial Hospital in Dunnville, Ont., reported many activities for 1954. The annual Florence Nightingale Tea brought in $75 and a tag day raised $256.46. Revenue from the marathon bridge was $217.60.

An "unholy alliance" is something in politics which, if it were on our side, would be forward-looking elements marching shoulder to shoulder.—*English Digest.*

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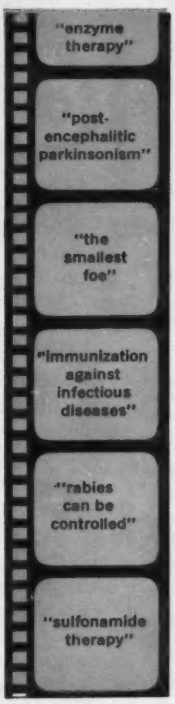

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C.H.A. Biennial Meeting

Parliament of Canadian Hospitals to Meet

ON MAY 9TH, the 13th biennial meeting of the Canadian Hospital Association will get under way at the Chateau Laurier in Ottawa. Once again, hospital representatives from across Canada will be offered a full three-day program. Reports on various association activities will be presented and there will be ample opportunity for discussion of vital issues which affect all hospitals. Meeting at the same time will be the Canadian Council of Women's Hospital Auxiliaries, while the Catholic Hospital Association of Canada will hold its annual meeting on May 6th and 7th.

An important item on the agenda will be a general session devoted to developments in the national health program since the last biennial meeting and discussion on questions pertaining to rehabilitation and mental illness. The Honourable Paul Martin, minister of national health and welfare, in addition to officially opening the meeting, will be the principal speaker at this session. A panel of senior government officials will be present for a question and answer period. Hospital participation in disaster planning will also receive the attention it merits — under the leadership of Dr. K. C. Charron and other officers of the Civil Defence Health Services.

Delegates will be given the opportunity to hear authorities speak on progress in hospital accreditation. Present to discuss its various aspects and what has been accomplished to date will be representatives from the Joint Commission on Accreditation of Hospitals, the Canadian Commission on Hospital Accreditation, and the Canadian Hospital Association Committee on Accreditation. Time will be allotted for discussion from the floor on this important topic. Another matter of special interest which will be brought before delegates is the use of national hospital statistics.

Activities sponsored by the Canadian Hospital Association will be put on review through the presentation of reports by the president, the treasurer, and the executive director, as well as the chairmen of committees on education and on accounting and statistics.

A highlight of the meeting will be the presentation of the George Findlay Stephens Memorial Award to Percy Ward of Vancouver. This will take place at a dinner to be held on Tuesday evening May 10th. Mr. Ward, well known in Canadian hospital affairs, is the executive secretary of the British Columbia Hospitals' Association (see page 39).

Local arrangements for this 13th biennial meeting are being made by a committee consisting of Father Henri Légaré, executive secretary of the Catholic Hospital Association of Canada; Sister Joseph Edmund of the Ottawa General Hospital; Douglas Peart, administrator of Ottawa Civic Hospital; and Gordon Hughes, Division of Hospital Design, Department of National Health and Welfare. ●

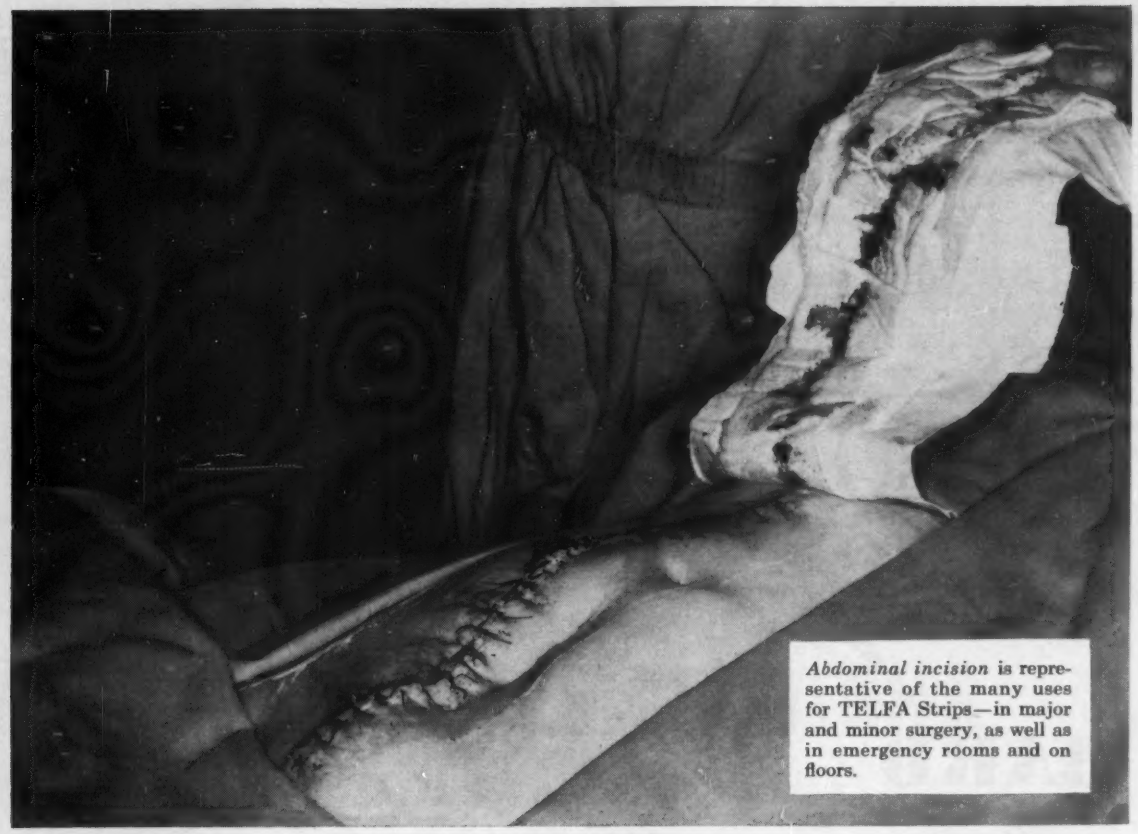
Social Service Department

(Continued from page 36)

the now Joint Commission on Accreditation of Hospitals, which stipulates that qualified medical social service personnel should be employed in an organized department. Every attempt has been made, in the face of a serious shortage of social workers generally, to bring up the standard of training; and there are now seven staff members with their M.S.W. degree, and five with their B.S.W. degree. The work of the department is carried on in three general areas; the outpatient department; the health centre for children; and the in-patient services, which includes patients in nursing homes. Separate confidential records on patients are kept within the social service department.

Social service work has changed very dramatically in the out-patient department over the past few years. Until quite recently the social workers' time was mostly taken up with responsibility for determining eligibility, admitting, supplying appliances and providing financial information. With the greatly increased help of the women's auxiliary, the role of the social worker has changed. In 1954 the volunteers of the women's auxiliary took over almost completely the function of admitting and rechecking eligibility. On January 1, 1955, they provided the funds to hire an admitting clerk to take responsibility for this job; but they still provide much individual volunteer time to help. This move was very consistent with their history of interest in the social service department, and their desire to see that the professional social workers have time to develop case work referrals among out-patients. The admitting clerk now handles most of the appliances, and nearly all of the funds for this work are supplied by the Women's Auxiliary. Being relieved of the clerical services has made it possible for the social workers to offer direct case work services to patients. This service includes the obtaining of social histories and making a social diagnosis of patients who are attending various clinics such as the psychiatric out-patient clinic. Follow-up work on a supportive level in the community or helping the patient to make an adjustment to his problem is carried out in consultation with the doctor. This helps to sustain patients on the outside who might otherwise become in-patients of the hospital. Referrals from many of the community's clinics request information in regard to the social and emotional aspects of the patient's illness, such as in diabetes, arthritis, asthma, heart cases, et cetera. Adjustments have to be made in family living because of certain illnesses and the social worker can help the patient to bridge the period of dismay and uncertainty and to come to an acceptance of his condition. Referrals come for people who need nursing home and boarding home care, or financial assistance, and these patients are helped with their attitude toward aging and the need to change their way of life. British Columbia has a great preponderance of aged patients in relation to the rest of Canada and a large number find their way to the out-patient department. Tact, patience and a knowledge of resources is essential in approaching their problems. A casework supervisor is in charge of all of the

(Concluded on page 66)



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because of proper flexibility and glassy-smooth surface.

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because of uniform lumen and woven eyes.

Size Selection Easy
because of patented color banding on smaller sizes
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because of fine materials and workmanship.

Long Life because repeated autoclaving or boiling causes no damage. Easily cleaned, disinfected and deodorized in cold solutions of Detergicide®.

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A total of 113 exhibitors will be exhibiting in the Textile, Scientific Instruments, Medical, Optical Supplies and Household Furnishings & Appliances Sections of this year's Trade Fair. These cover exhibits from at least 12 countries.

Address your requests for information and accommodation to: The Administrator, Canadian International Trade Fair, Exhibition Park, Toronto.

8th Annual

CANADIAN International TRADE FAIR

TORONTO CANADA MAY 30th TO JUNE 10th 1955

YOUR GATEWAY TO WORLD TRADE

OPERATED BY THE GOVERNMENT OF CANADA TO PROMOTE YOUR BUSINESS

Social Service Department

(Concluded from page 62)

social service program in the out-patient department.

There are three social workers in the health centre for children. There is a great sense of team spirit in this setting. One of the social workers has a full-time job on the pediatrics wards, taking referrals for emotional problems affecting illness, social histories, behaviour problems, appliances and discharge planning. The regular worker in the out-patient clinic takes referrals for similar problems in a very busy area. At one point she may get a referral to work with a problem of eneuresis, and on the other she may be asked to find funds to provide a hearing aid for a child whose parents cannot afford to purchase one for him. The third worker in the health centre for children takes only referrals for the psychiatric clinic. She does an intensive job of working up referrals for psychiatry and provides a social history and diagnosis for a psychiatric conference. She then may do follow-up treatment on a restricted number of cases in consultation with the psychiatrist.

The adult in-patient services are quite varied and the social workers carry out their function in specific services. There is one worker for the surgical and orthopaedic wards; one for medicine; one for semi-private patients and the infectious diseases hospital; and one who spends most of her time in two large nursing homes attached to the hospital under contract. Many of the referrals on these wards are for nursing home and boarding home placement; but there is an ever-increasing number of referrals also for direct work with patients who need help with social problems.

The hospital has a large maternity out-patient department as well as an in-patient department. There is much to do on these wards and clinics in relation to social work. To date, a nurse social worker has been taking care of these problems but more recognition is being given to the need for a full-time social worker. Many of the unwed mothers are from outside of the city and province; and most of them do need help with planning for their children.

Besides working directly with patients, the department works in very close liaison with the well developed health and welfare resources in British Columbia; and a great many problems are referred out to these agencies. All of this work helps to ensure that each patient of the hospital gets as much individual attention to all of his problems as possible.

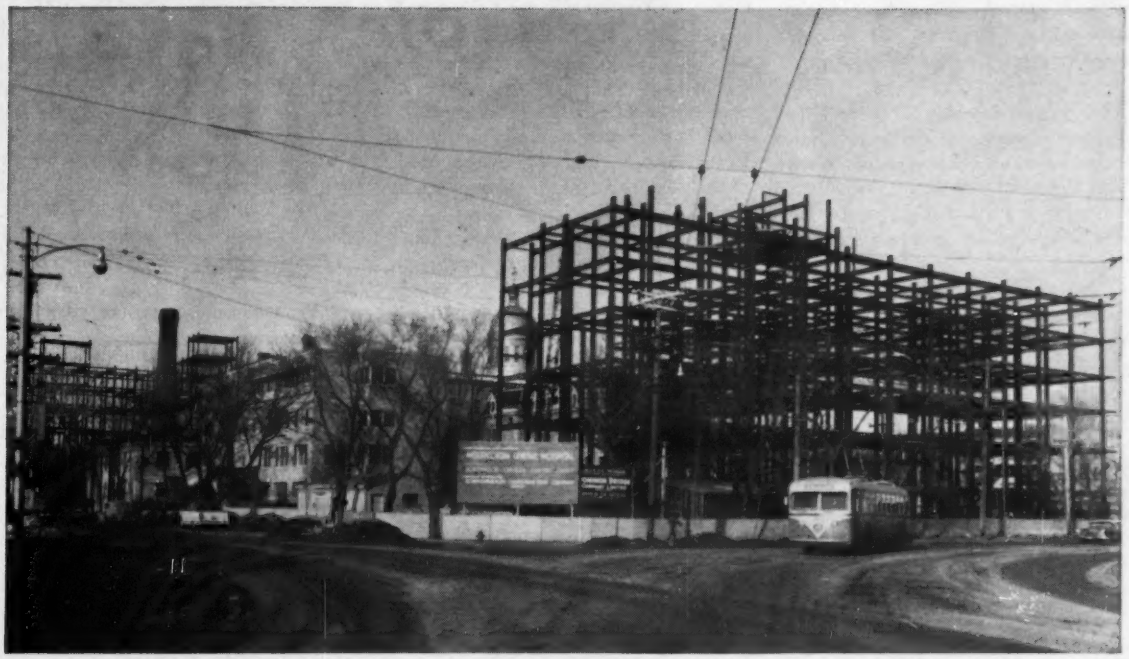
National Hospital Week to be Observed in May

National Hospital Week, sponsored annually by the American Hospital Association, will be observed this year from May 8th to 14th. The theme will be "Your hospital . . . a tradition of service". To help hospitals in organizing a program for National Hospital Week, the American Hospital Association has prepared a kit of materials.

In Sir Winston's Name

To mark the 80th birthday of Sir Winston Churchill, the Gauge and Toolmakers' Association of Great Britain have endowed a bed in Sir Winston's name at the Great Ormond Street Hospital for Sick Children. — *Hospital and Health Management*

going up!



The MISERICORDIA GENERAL HOSPITAL

in Winnipeg

To meet the constantly increasing demand for hospital accommodation in Winnipeg, the Misericordia Hospital is undertaking a major job of enlargement and modernization.

Added bed capacity means added clean linen requirements.

To maintain this important service, additional laundry equipment is being supplied by Stanley Brock Limited. The new installation will produce an economical and efficient operation in the laundry department.

When you require advice on any laundry problem—large hospital or small—your Stanley Brock Technical advisor is ready to help. Please contact our nearest branch.

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STANLEY BROCK LIMITED

Environment and Cancer

(During the month of April, the Canadian Cancer Society is conducting a national campaign to create and sustain a public attitude toward cancer that will motivate people to see their doctor at a time when treatment may be most effective; to raise funds to support cancer research and for other purposes related to cancer control.)

The recent interest in the relation between cigarette smoking and lung cancer has caused many people to ask: "Are there substances with which we come into contact that can cause cancer?" The answer to this is a definite "Yes".

There are in our environment cancer-causing agents. That much is known for sure. But just how important a part they may play in the development of human cancer is not definitely known.

For instance, ultra-violet rays from the sun may cause skin cancer. But, a recent survey sponsored by the Canadian Cancer Society shows that skin cancer is more common in white people than among Canadian Indians. The same is true of the American negroes who have very little skin cancer. These observations suggest that the pigment of the skin may have a protective role to play.

It is also an established fact that x-rays and gamma rays, which will kill cancer cells and cure certain types of cancer, may cause cancer, too. The incidence of leukemia (cancer of the blood) is said to be 10 times as great among doctors using x-ray and radium as among doctors not exposed to these forms of radiant energy.

Persons exposed to radiation caused by atom bomb explosions have also been shown to have a greater tendency to develop leukemia than persons not so exposed.

Soot, lamp black, tar and crude oil contain a chemical called benzpyrene which will produce cancers when painted on the skin of experimental animals. There is no doubt that dwellers in industrial areas breathe in considerable quantities of these objects and many observers believe that they, as much as tobacco smoking, may be responsible for the fact that the lung cancer death rate in males has doubled in Canada in the past twelve years.

Reports from England, Switzerland, Italy and the United States show more cancer of the bladder among workers in the dye industry than among others. In one American city, for instance, bladder tumours were found in about 10 per cent of dye-industry workers. In this same connection a German scientist, Dr. Otto Warburg, who won the Nobel prize for medicine in 1931, recently suggested a ban on the dyeing of footstuffs with aniline dyes because of the possibility that these dyes might cause cancer.

However, officials of the Canadian Cancer Society point out that although these cancer-causing agents are known to exist it is not possible to avoid them all in our modern society. Furthermore, it would seem that less than one per cent of all cancers occurring in Canada are attributable to known causes. They emphasize that each person must be on the alert to spot signs of cancer in its early stages and see the family doctor if any symptoms are present.

The seven danger signals that may indicate the presence of cancer and which should be checked on at once are:

1. Any sore that does not heal—particularly around the face or mouth;
2. A lump or thickening in the breast or elsewhere.
3. Unusual bleeding or discharge from body openings.
4. Any change in a wart or mole.
5. Persistent hoarseness or cough.
6. Any change in normal bowel habits.
7. Persistent indigestion or difficulty in swallowing.

Constant Sanitary Control Needed Over Shellfish Producing Areas

The importance of constant sanitary control over shellfish producing areas, in the interest of public safety and of the national economy, was emphasized by the Hon. Paul Martin, federal health minister, at a meeting of the Canadian Shellfish Committee. Mr. Martin stated that control of toxicity in shellfish areas was of vital concern to both Canada and the United States. Interest in this phase of conservation was increased by the occurrence of typhoid fever in the United States in 1925, caused by the consumption of shellfish from waters polluted by sewage. The Interdepartmental Shellfish Committee which met recently is composed of representatives of the federal Department of Fisheries, including the Fisheries Research Board, and the Department of National Health and Welfare. Agenda for the sessions include studies of shellfish control and processing methods and research on the purification of soft-shelled clams from moderately-polluted areas.

In Canada, the control of producing areas is largely the responsibility of the Department of Fisheries but closures of polluted sections of the area are based on field work and recommendations by the federal health department. The health department's Public Health Engineering Division makes sanitary surveys of producing areas, examines shucking plants, and handling methods and issues export certificates. The Food and Drug divisions check on the quality of marketed shellfish and the Laboratory of Hygiene carries on bacteriological surveys of producing areas, toxicity tests and research.

Rotary Club Grants for Medical Research Projects

The Rotary Club of Toronto, Ont., is sponsoring a dental and two medical research projects, as well as a medical lectureship. The money for the projects, $10,100, will be appropriated from Easter Seal funds, with the approval of the Ontario Society for Crippled Children. The University of Toronto has agreed to provide supervision. Fields of study will be: bone growth relating to diseases of the upper thigh bone — $3,500; the relation of prolonged and difficult labour to brain damage resulting in the crippling of newborns — $3,600; and a continuation of dental research — $2,500. The lectureship ($500) is to provide an annual address at the University of Toronto to the medical profession and to medical students, by an authority on some aspect of crippling diseases.

One Summer means a lot of Swallows!

Time to stock up with low-cost Dominion Glass Fountainware

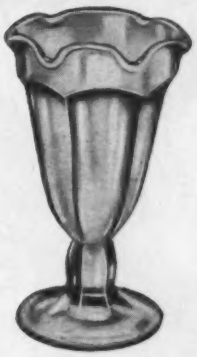
Increased summer custom can bring even greater profits to your ice-cream trade when you can cut glassware costs with Dominion Glass Fountainware. This range of quality pressed glassware *costs less*—yet gives you all the sales advantages of gleaming, crystal clarity in attractive designs . . . all the sizes and shapes you need. Ask your glassware distributor to show you Dominion Glass Fountainware.

DOMINION GLASS COMPANY *Limited*

TABLEWARE AND SPECIALTY DIVISION
Wallaceburg, Ontario

***General Office*—Montreal • *Sales Offices*—Montreal, Quebec City, Halifax, Toronto, Hamilton, Winnipeg, Redcliff, Alta., Vancouver**

Please address all enquiries and orders to your Glassware Distributor



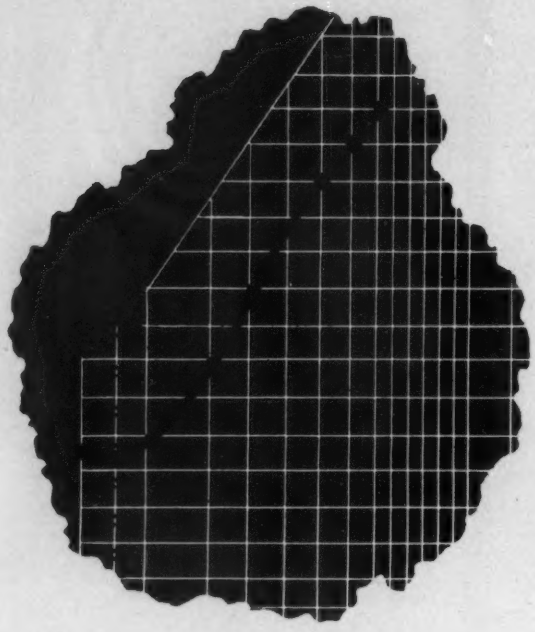
TULIP SUNDAE—an all-time favourite. As made by Dominion Glass, these are crystal-clear, sparkling, economically priced. Come in 4½ and 6½ oz. sizes.

SUNDAE—this attractive shape comes in 3¼ oz. size. Clear glass, handsomely fluted. Ask your Glassware Distributor for prices. You will be pleased at the small cost.

SUNDAE—this 4¼ oz. size makes the serving look big. With an extra sturdy stem, this is a gleaming, quality glass, reasonably priced.

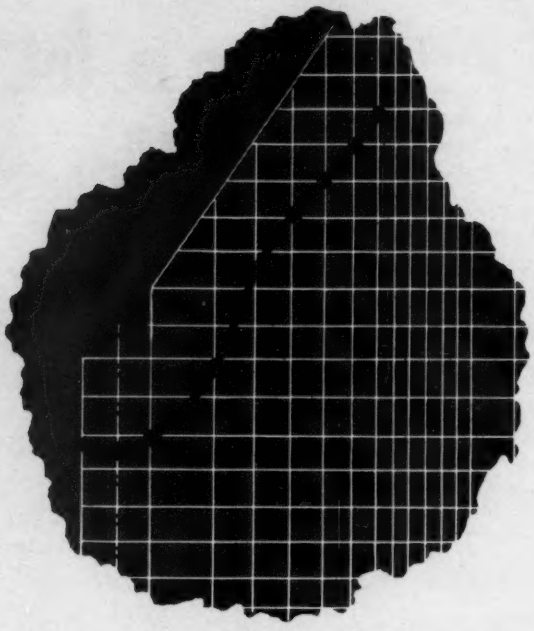
FOOTED SODA—popular with younger customers. Durable, with a high lustre. Dominion Glass sodas cost you less. Come in 12 oz. size only.

S-M-A FED



Typical growth curve of S-M-A fed baby Schematic Section on Wetzel Grid

BREAST FED



Typical growth curve of breast fed baby Schematic Section on Wetzel Grid

. . . The growth patterns of S-M-A and breast fed babies are very much alike. Clinical studies have shown that development traits, including height and weight, are parallel —and often identical—for S-M-A and breast fed babies. This may be expected because the nutritional qualities of S-M-A satisfy infant requirements essential for sound, sturdy growth.

S-M-A Powder—tins of 1 pound

S-M-A

POWDER

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WALKERVILLE, ONTARIO
WINNIPEG - MONTREAL

THE NEW MULTI-PURPOSE BABY'S HAVEN MODEL NB-50AP

. . . Offers these extra advantages . . .

- **ARM PORTS**—for easy access and handling

and

- **THE OXYGEN DILUTION METER** for accurate and positive oxygen concentrations

FULLY APPROVED BY:
★ C.S.A.
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Plus—

THESE OUTSTANDING FEATURES:

- Built-in thermometer.
- Thermostatic control sensitive to plus or minus 1 degree.
- Safety thermostat controls high temperature limit.
- Simple and highly efficient humidity system.
- Oxygen inlet for ¼" hose.
- Can be used for cold humidification with Alevaire by means of the MHE Nebulizor or the Oxygen-Dilution Meter.
- Transparent panels, front, back and top.
- Saran fabric adjustable frame supports infant and permits heat plus humidity to pass through. No mattress is used.
- Three-inch ball bearing casters, two equipped with "Swivelocks".
- Full drop front.
- Safety hinged top to avoid danger of accidental closure.
- Disposable porthole sleeves.

Fisher & Burpe Limited

PHYSICIANS AND HOSPITAL SUPPLIES

TORONTO • WINNIPEG
EDMONTON • VANCOUVER

Pierre Mercier & Cie Ltee.
Montreal

Rehabilitation

(Concluded from page 47)

to keep in mind because it reveals the inaccuracy of evaluating the rehabilitation institution on the basis of beds provided and occupied.

In other respects the rehabilitation hospital is similar to the general hospital in that it requires highly qualified personnel, much equipment, and considerable physical space for its varied departments. The personnel who practise physical medicine and rehabilitation determine success or failure. This is so because not only is it necessary to have highly trained individuals, with the required diplomas, from the medical director right down the line, but also because these persons must have a rather unusual type of personality and must exercise an extraordinary degree of co-ordination of effort. Smooth team work is imperative. This can be readily understood when it is noted that physical medicine and rehabilitation demand the skills of psychiatrists, psychologists, physiotherapists, occupational therapists, and speech therapists, as well as the best efforts of medical social workers, vocational and placement officers, and a competent administrative and secretarial staff. Infinite patience and sympathetic understanding must exist between the patient and every person with whom he comes in contact in the course of rehabilitation. Just one weak link in the chain will prolong the process or perhaps invalidate it.

It will be seen, therefore, that if we are to develop physical medicine and rehabilitation, which increasingly demonstrates its practicality and economic advantages, we must have a new approach. Treatment centres devoted to physical medicine and rehabilitation must be considered on their own merits, with recognition given to their specific requirements, which are not those of a general hospital.

Provincial Notes

(Concluded from page 52)

cent. A letter from Dr. C. H. Beevor-Potts to the Board made it clear that the length of patient-stay was being lengthened by lack of the required operating room space. Since funds are not available to build a new hospital, it was agreed to take steps immediately toward constructing a wing which would for some years enable physicians to do a good job more efficiently.

* * *

NELSON. The Kootenay Lake General Hospital Society has signed a contract with two architectural firms to design the proposed $1,800,000 hospital in Nelson. On this project Paul D. Smith, architect, from Trail, will work in partnership with the firm of Ilsa J. C. Williams and David P. Fairbank of Nelson. Under terms of the contract, plans are to be ready for tender within the current year. A start has already been made on the plans and a double corridor design is proposed.

* * *

RICHMOND. Proposed construction of a modern 100-bed hospital for this community moved a step forward in February when the Richmond Hospital Society received its official charter. The provincial government's approval is still awaited.●

Stephens Memorial Award

(Concluded from page 39)

Statistics, government health departments, and hospital accountants, Percy Ward was very pleased. It represented in tangible form what he and the committee had worked for over many years. Often it seemed there were insurmountable obstacles to be overcome and on many occasions he and his committee in those early days of standardization thought of themselves as voices crying in the wilderness. Yet they persevered and now the benefits of standard accounting procedures for all Canadian hospitals have arrived.

In the province of British Columbia Percy Ward has been referred to as "Mr. Hospital". It has been said that he lives for the hospitals. Certainly he has made hospitals a life study but, also, he is a man who has many interests and hobbies—he can wield an axe or a hammer as efficiently as he can interpret a point of law. One has to know Mr. Ward to appreciate fully his rare and dry sense of humour, and he is just as good a listener as he is a lecturer. Nothing is too trivial to hold his interest if a person desires his help. Perhaps Mr. Ward's outstanding attribute is that it makes no difference to him how low one's station in life may be or how distinquished either, to rich or poor he is always the same, ready and willing to lend a helping hand. Those who have worked with Percy Ward respect him as a man and admire his great contribution to hospitals. His many friends will be pleased that his outstanding contributions to hospitals in Canada are now recognized by the highest honour which the Canadian Hospital Association can bestow—the George Findlay Stephens Memorial Award.

Recipients of the award since its inception were the late Dr. A. K. Haywood of Vancouver (1949), the late Dr. Fred W. Routley (1950), Dr. A. Lorne C. Gilday of Montreal (1951), Dr. Andrew F. Anderson of Edmonton (1952), Dr. G. Harvey Agnew of Toronto (1953), and A. J. Swanson of Toronto (1954).

Need for Trained Social Workers

Professionally-trained social workers will soon be in a minority in welfare establishments if present trends continue, according to Dr. John O. Moore, director of the School of Social Work at McGill University, Montreal. Addressing a meeting of the board of directors of the Welfare Federation of Montreal recently, Dr. Moore said that the gap between positions in social work—created by rapid population growth—and the number of trained workers to fill these jobs was growing wider. The gap could be partially closed, he suggested, if welfare agencies would undertake a careful job assessment survey, to determine actual needs for trained workers. Agencies might also undertake a work and study program so that social work students could pay for their studies by part-time employment with agencies of their choice.

Spiced Pie Crust

A spiced pie shell is an interesting variation. Add a teaspoon of ground cinnamon to a crust for an open-face cherry pie, ground ginger for custard pie, ground mace for lemon pie. — *Institutions Magazine.*

From the Code of

Hospital Ethics

Part II*

Staff and Personnel

Responsibility

It is the responsibility of all who have anything whatsoever to do with the care of the patient to make every effort to ensure that all patients receive the best possible care with minimum delay, with the utmost of skill and efficiency, and with the greatest of personal consideration and tenderness.

Every courtesy and consideration should be shown by all members of the hospital personnel to any visitors to the hospital.

Secrecy

The onus of secrecy which professional codes of ethics have placed upon the physician and the nurse applies in like manner to every member of the hospital personnel. Under no circumstances may any information of a personal nature gained within the hospital be divulged to other than those authorized to receive such information in the course of the duty.

Commissions

Without the approval of the governing body, no hospital employee or any person connected with a hospital shall receive compensation or reward from any individual or agency because of the hospital position occupied which has not been earned as salary or wages in the course of hospital duty.

Professional Organization Encouraged

Members of the various professions and vocations included in the hospital organization will uphold the dignity and honour of their own special lines of endeavour and of the hospital as a whole by becoming members of their respective professional and technical scientific societies and, consistent with the discharge of their hospital responsibilities, by devoting efforts and means to the elevation and advancement of their own particular field.

Professional Codes of Ethics

It is the duty of the hospital, in so far as the hospital personnel and regulations can render assistance, to aid and support the members of all professional groups in their observance of the codes of ethics of their respective professional organizations.

*See "The Canadian Hospital, March, page 66.

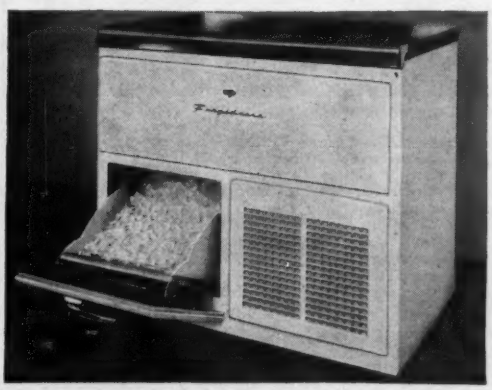
The Hospital's Shop Window

The out-patient department of a hospital is its most viewed shop window and if it is well-organized and sympathetically run nothing can make a more effective contribution towards improving hospital service public relations — *"The Hospital", London, England, Feb., 1955.*

Patients appreciate pure, plentiful Frigidaire ice!

For as little as 26¢ a day up to 200 lbs. of crystal clear ice!

Frigidaire Ice Cubes or Cubelets are made the world's most trouble-free way



New model . . . beautiful new styling with features that give extra performance, convenience, savings!

New Frigidaire Ice Cube Makers banish the mess and bother of buying ice—and save up to 90% of its cost. Can actually pay for themselves in the first year. And no other ice maker made is as trouble-free as a Frigidaire. No noisy grinders, choppers, chains or knives to get out of order. Completely automatic. Ice is pure, hard frozen, solid, crystal clear. No odd shapes. Meets hospital sanitary standards.

Choose regular cubes or the new tiny cubelets that are ideal for quick-cooling any drink or food . . . handy for ice packs and other hospital uses. New improved model can be changed quickly from regular cubes to cubelets and back. New "ready serve" door simplifies cube handling. Only 44¼″ long, 31⅜″ deep, 38⅝″ high—compact for space-saving installation. Meter-Miser mechanism warranted for 5 years.

Find your Frigidaire Commercial Refrigeration Dealer's name, listed in the Yellow Pages of your phone book. Or write: Frigidaire Products of Canada Limited, Toronto 13, Ontario.

Frigidaire Ice Cube Makers

Built and backed by General Motors

Coming Conventions

April 18-22—A.H.A. Institute on Engineering, King Edward Hotel, Toronto.

May 2-6—National League for Nursing Convention, Kiel Auditorium, St. Louis, Mo.

May 6-7—Annual Meeting of the Catholic Hospital Association of Canada, Ottawa.

May 6-7—A.H.A. Institute on Insurance for Hospitals, Palmer House, Chicago.

May 9-11—Canadian Hospital Association Biennial Meeting, Chateau Laurier, Ottawa.

May 9-11—National Council of Women's Hospital Auxiliaries Association Convention, Chateau Laurier, Ottawa.

May 15-20—Annual Meeting of the Catholic Hospital Association of the United States and Canada, St. Louis, Mo.

May 30-June 3—Maritime Hospital Association Convention, Prince of Wales College, Charlottetown, P.E.I.

May 30-June 3—Ninth International Congress of the International Hospital Federation, Lucerne, Switzerland.

June 5-8—Annual Meeting of the Canadian Society of Laboratory Technologists, Bessborough Hotel, Saskatoon, Sask.

June 6-10—A.H.A. Institute on Public Relations, Knickerbocker Hotel, Chicago.

June 6-11—Annual Convention of the Canadian Tuberculosis Association, Winnipeg, Man.

June 10-11—Associated Hospitals of Alberta, University of Alberta, Edmonton.

June 13-16—A.H.A. Institute on Central Service Administration, Sheraton-Mt. Royal Hotel, Montreal, P.Q.

June 13-18—Western Canada Institute for Hospital Administrators and Trustees, University of Alberta, Edmonton.

June 20-24—Conjoint meeting of the British Medical Association, the Canadian Medical Association and the Ontario Medical Association, Royal York Hotel, Toronto, Ont.

June 27-29—Canadian Dietetic Association Convention, Royal York Hotel, Toronto, Ont.

June 27-29—Annual Meeting of the Comité des Hôpitaux du Québec, Palais du Commerce, Montreal, P.Q.

Aug. 13-14—Institute on Hospital Pharmacy, Vancouver, B.C.

Aug. 15—Annual Meeting of the Canadian Society of Hospital Pharmacists, Vancouver, B.C.

Aug. 24-25—Maritime Conference of the Catholic Hospital Association, Moncton, N.B.

Sept. 7-10—Annual Meeting of the Canadian Society of Radiological Technicians, Windsor Hotel, Montreal, P.Q.

Sept. 14-15—Catholic Hospital Conference of Alberta, Harris Sky Rooms, Calgary.

Sept. 17-19—Annual Meeting of the American College of Hospital Administrators, Traymore Hotel, Atlantic City, N.J.

Sept. 19-22—Annual Meeting of the American Association of Hospital Consultants, Atlantic City, N.J.

Sept. 19-22—American Hospital Association Convention, Atlantic City Convention Hall, Atlantic City, N.J.

Oct. 9-10—Catholic Hospital Conference of British Columbia, St. Vincent's Hospital, Vancouver.

Oct. 11-14—British Columbia Hospitals' Association Convention, Vancouver.

Oct. 24-26—Ontario Hospital Association Convention, Royal York Hotel, Toronto, Ont.

Oct. 24-26—Annual Meeting of the Saskatchewan Hospital Association, Bessborough Hotel, Saskatoon, Sask.

Oct. 29-31—Annual Meeting of the Canadian Association of Occupational Therapy, Toronto, Ont.

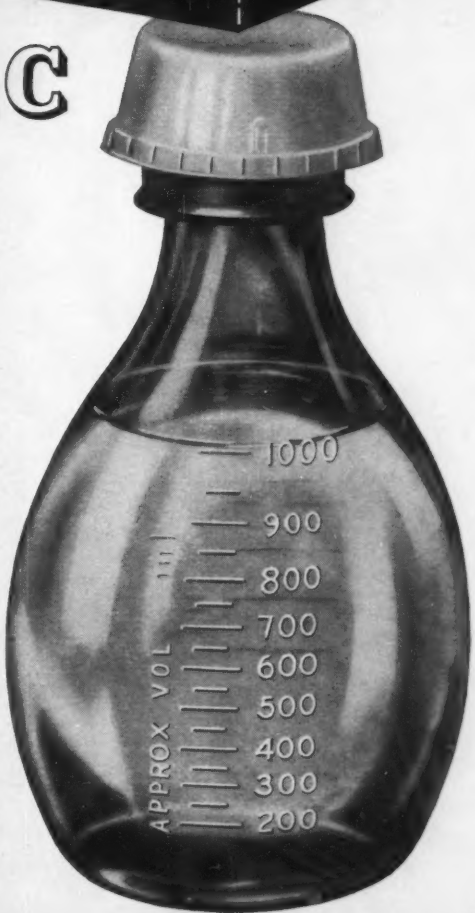
MACALASTER BICKNELL
Parenteral Corporation
CAMBRIDGE 39, MASSACHUSETTS

Introduces

Improved SELF-SEALING

POUR-O-VAC

The Macalaster Bicknell Research Laboratory presents a significant improvement in the Pour-O-Vac Technique, already America's most widely used sterile fluid flasking method.



★ **MODIFIED SELF-SEALING CAP MAY BE UTILIZED WITH EXISTING POUR-O-VAC COLLARS AND FLASKS.**

This new self-sealing cap is of pure nylon, and virtually indestructible. The one-piece moulded nylon cap is light, easy to handle, and provides mechanically for approved aseptic technique because it has no hard-to-clean recesses. Placed on the container before sterilization, it is held in place during sterilization, then automatically seals itself by vacuum at the end of the sterilization cycle.

★ **SPECIAL RUBBER COMPOUND COLLAR UNMATCHED FOR WEAR — and it's ODORLESS!**

The utility of the efficient and unique patented design of the Pour-O-Vac Collar has been still further improved. Macalaster Bicknell and affiliate engineers have now perfected a resilient odorless compound which will withstand almost endless wear and exposure to high temperatures. This new compound used in the ridge and groove-free Pour-O-Vac Collar sets a new record of achievement.

★ **PREFERRED PEAR-SHAPE FLASK — PROVEN STRUCTURALLY STRONGER BY GLASS MOULDING PRINCIPLES.**

Macalaster Bicknell Company's pear-shaped Pyrex flask is structurally the strongest and safest glass container for sterilizing fluids known to science. Glass bottles are really bubbles blown of liquid glass inside an iron mould. The more the mould distorts the shape of a natural bubble, the more weak spots the final container acquires. Compare the shape of Macalaster Bicknell's flask with the shape of a hanging drop of liquid. There is the secret of the unchallengeable natural forces which make this pear shape flask so near theoretical perfection.

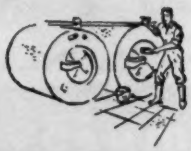
STEVENS
125th ANNIVERSARY YEAR
1830 - 1955

TORONTO WINNIPEG CALGARY VANCOUVER

ORIGINAL DISTRIBUTORS OF THE FENWAL SYSTEM

DAIRY CLEANING

the Better Way



CRESCENT CLEANSER NO. 600

ORDINARY CLEANSER

. . . attacks only the *surface* of the dirt . . . cleans by tedious "wear-away" method.

No. 600 SPECIAL WETTING ACTION

. . . gets right under dirt and soil . . . saves scrubbing, always kind to tender hands.

GIVES YOU ALL THESE ADVANTAGES

- ★ More Thorough Cleaning
- ★ Faster Action
- ★ Less Labor
- ★ Greater Safety
- ★ Added Versatility
- ★ Lower Cost

Dairy Cleansing is a *special* operation, requiring a *special* cleanser . . . one that combines speed and extra efficiency. BRUNNER MOND CRESCENT CLEANSER No. 600 gives you both . . . plus lower cost!

The secret of CRESCENT CLEANSER NO. 600's "better way" cleaning is its special wetting action, which gets under the dirt, loosens it, emulsifies it and lifts it off the surface. The result — a new low bacteria count and sweeter equipment.

CRESCENT CLEANSER No. 600 saves *time* . . . because it cleans *faster*. It saves *your hands* and *your equipment* . . . because it will not harmfully affect the skin or the surface being cleaned. And it saves *money*, too . . . tests prove that one pound of "600" produces better results than greater quantities of other cleansers.

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Crescent **CLEANSER No. 600** *for All Cleaning Operations!*

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Yardstick In Progress

(Continued from page 48)

of net earnings is received from patients paying their own bills; and from patients whose bills are paid by a variety of third parties. Much of the cost of hospital construction to-day is borne by governments; and they must know how these funds fit into the total picture of plant funds and the application of these funds. All this information can be derived from your financial returns.

For Efficient Operation

From the point of view of the individual hospital, the preparation of these returns is based on the same sort of reasoning which makes you follow standard accounting and statistical procedures in your hospitals. These procedures are a vital element in efficient hospital administration. Without an efficient accounting system or a statistical record system, neither the medical superintendent nor the administrator knows in what direction the hospital is going. Surely it is obvious that you must know such things as the cost of the various patient services to the hospital and the infant mortality rate in the nursery.

I know that you will agree that such information is absolutely essential to the efficient operation of the hospital; but it is equally important that both the financial and statistical data should be kept in such a manner that it is comparable with all other hospitals. In other words, accounting and statistical procedures should be uniform throughout all our public hospitals. As you know, this has been the aim of the Canadian Hospital Association, through the introduction of the *Canadian Hospital Accounting Manual*, and also of your provincial government and the Bureau of Statistics with the introduction of standard financial and statistical schedules.

In order to compare your financial and statistical data with similar information from other hospitals the type of national hospital statistics system which we have in Canada is necessary. There must be some central body with the responsibility of collecting, tabulating, analysing and publishing this information at both the provincial and federal levels. These statistics can then be taken by the individual hospital and compared with its own figures. The information

which you supply on the General and Financial Schedules is tabulated by us in such a manner that it can be used in this fashion as well as by other consumers of the data such as federal and provincial governments, the Canadian Hospital Association and so on.

Forecasting

There are many purposes which can be served by a uniform system of statistical and financial procedures and records in hospitals.* The first of these is to assist the administrator and the board in planning activities. I realize, of course, that forecasting is a hazardous undertaking; but if the hospital is to keep abreast of community needs it must have some idea of what those needs are. In addition, it must have adequate records which will show how community needs have been met in the past. In assessing the long range situation many factors must be taken into account such as increases or decreases in the population served by the hospital, existing hospital facilities, indigent load, death rates, birth rates, ethnic and economic backgrounds of the population, number of personnel available, changes in medical practice, use of diagnostic aids, and improvements in equipment. Each of these factors can be measured providing the hospital maintains adequate records.

The most important single tool for short range planning is the budget. A properly designed budget which is based on efficient accounting records will make it easier for the hospital to adjust departmental operation within the general plans for the hospital; it will allow regular comparisons between actual operating results and plans; and it will indicate or force corrective action to be taken so as to ensure operation at a satisfactory level of relationship between income and expense

Control

The second purpose of a system of financial and statistical reports in hospitals is to aid the administrator to control the activities of the hospital. Some of the reports I have in mind relate to the budget; and some are concerned with the services performed

* *Much of what follows is from "A Vital Management Tool", James W. Stephan, Hospitals, July 1954, Vol. 28, pp. 66-68.*

by departments over a specific period of time. Most of these reports should be submitted at monthly intervals, thus indicating areas where corrective measures are necessary before damage is done.

The budget that was developed for planning purposes becomes a vital control measure during the year of operation. Income and expenses are compared with amounts budgeted and deviations tend to point up items that need either explanation or correction.

I have tried to indicate the value of systematic financial and statistical reports to the hospital. When these various reports are combined, we arrive at the answers to the sort of questions asked on our annual reporting schedules. But in addition to answering these questions a systematic hospital record system, such as that outlined in the *Canadian Hospital Accounting Manual*, should provide various ratios and indices which are the yardsticks with which the administrator can measure the progress and efficiency of his hospital. I will mention a few such indices and ratios which I think might be useful in this regard. These are: the percentage of bad debt loss to gross income from patients; percentage of total deductions to gross income; analysis of income indicating the percentage from the various sources; operating income per patient day; the relation of income to expense of special departments, such as operating rooms, delivery rooms, laboratory, x-ray and operating expense per patient day, broken down by departments or services, and by the major items of salaries and wages; medical, surgical and sterile supplies; and drugs, medicines and prescriptions.

Turning from the financial to the statistical, there are out-patient, emergency room visits, number of meals served, number of nursing hours per patient per day by department, death rate, autopsy rate, post-operative death rate, maternal mortality rate, infant mortality rate and many others.

It should be pointed out once again that the types of rates and indices referred to can be derived from the basic information which you now report to us and which is collected according to the procedures outlined in the *Canadian Hospital Accounting Manual*. These ratios and indices gain significance when they are compared with similar measurements in hospitals of a similar type and size. For this reason, we at the Dominion Bureau of Statistics are planning to include them in the analysis of the figures you send us and which we publish annually. Such measurements can be made even more useful when they are recorded by the hospital for a number of years. Then the administrator can use these yardsticks to determine the progress his particular hospital has made.

A.C.H.A. Preceptor Conferences

The American College of Hospital Administrators scheduled three preceptor conferences for 1955. The first was held in New York this month and the other two will be in June. Of these the earliest will be held at the Congress Hotel in Chicago, June 3 and 4, and the second at the University of California, Berkley, Cal., June 20 and 21. Applications may be sent to the College, 620 North Michigan Avenue, Chicago 11.

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Kenya Scientists Solve River Blindness Riddle

It is expected that within two years onchocerchiasis, one of the most puzzling and dangerous diseases in Africa, will have disappeared from Kenya as the result of work undertaken by government scientists. The disease, more commonly known as river blindness, is caused by microscopic worms carried by a small fly distantly related to the tsetse. The worms multiply under the human skin and gradually make their way to the eyes, which they quickly destroy. Total or partial blindness invariably results from the disease.

Government teams have worked in the bush and dense forests of the Nyanza Province highlands for over 30 years in an effort to solve the riddle of the fly's life cycle. During their surveys, the research workers covered thousands of miles on foot through some of the most difficult country in Africa.

The research was in the hands of J. P. McMahon, a senior entomologist of the Medical Department's Division of Insect-borne Diseases. It was Mr. McMahon who, after years of disappointment, found that the larva and pupa of the fly attached themselves to a certain species of freshwater crab found in Nyanza streams. By dosing the rivers with a DDT solution it is possible to exterminate the surrounding area's fly population completely.

Already Mr. McMahon's teams have exterminated the fly in four infested areas in Nyanza. This year he plans to tackle the last stronghold in the Province's northern highlands. This achievement means that thousands of Africans who from childhood have been tormented by the fly now know that their children will grow up free of this age-old scourge. Other Kenya scientists are now experimenting with drugs to cure people already infected by the disease. — *"The World Veteran", December, 1954.*

Sausage 'n Apples

Glazed apples and spicy sausage cakes are delicious with hot fluffy rice. Sausage gravy and light biscuits may be added. To prepare the apples, core them but do not peel, and slice into 1½-inch rings. Sprinkle with sugar and brown lightly in the fat remaining after sausage has been cooked. — *Institutions Magazine.*

Social Worker—Hospital Team

(Concluded from page 34)

social worker. In the process of finding facts about the patient, the nurse can help. She, of course, will contribute to the social worker's knowledge of the patient, of his family and of his environment. A deeper understanding of the patient can be given to the nurse by the social worker. The nurse will then find that her nursing care may be more effective. It is well understood that the doctor takes the leadership; but, as the nurse and the social worker have common interest (in a patient's care), they should work together with the patient. For example, the nurse is well aware of how much the patient had been able to do for himself while in hospital and what nursing care he will need at home. On the other hand, the social worker knows what facilities there are at home for this specially needed care, and how much the family can be expected to co-operate. Together, the nurse and the social worker will help the patient work out a plan to meet his needs within the limitations of his surroundings.

. . . and the Administrator

The question is: Has the medical social worker any value to the administrator? If the social worker is assigned to the admission service, she can certainly help the administrator in many ways: (1) in the financial classification; (2) in selecting the type of accommodation most suitable to the patients needs; and (3) in helping the administrator understand the needs of the patient when he is ready for convalescence. As an educator she can also be of service to the administrator. For example, as an instructor to the school of nursing, she will be able to explain how the department of social service operates; and its relations to the patient, doctor, nurse, and administrator. Furthermore, if she is given a professional status, she can make valuable contributions at departmental and staff meetings.

The administrator will find that the social worker can render invaluable services through assisting in effective discharge of patients, helping place them in convalescent homes upon leaving the hospital or returning them to their own homes.

The medical social worker can serve efficiently on committees within the hospital or in the community. By serving effectively on these different committees (within or without the hospital), the medical social worker contributes a sympathetic and intelligent knowledge of hospital functions. Thus he or she is a good public relations' builder. The medical social worker's interpretation of hospital activities will strengthen community relationships and promote group thinking and planning.

Small hospitals encounter many difficulties in obtaining the services of a medical social worker. But in large hospitals, especially in cities, where community agencies are numerous, a medical social worker could be, as I have said, of great value to the hospital by creating a friendly atmosphere with all these agencies and thus help the hospital and especially the patient.

This kind of work requires a very intelligent and competent medical social worker. When that person is found, the hospital authorities should give her a chance to express her views, give her a professional status in the hospital, and co-operate with her 100 per cent if she is to help detect the social factors behind illness. ●

Diet Kitchen

(Concluded from page 50)

work area. According to the original floor plans, it was intended for the dishwashing unit. Consequently it was equipped with the necessary plumbing for the installation of a sink. This unit, while instrinsically a section of the main kitchen, is separated from it by three part-walls thus providing the necessary work area for diet purposes.

Adequate work surfaces, cupboards, shelves and desks were built for convenience and comfort in work. The material used was green arborite and stainless steel. Necessary electrical equipment was installed.

An Office for the Dietitian

The room adjoining the men's dining room was used for the women's dining room. While pleasant in appearance, it was too small to accommodate the increasing number of employees. The room was converted into the therapeutic dietitians' office with ample space for office equipment, plus work surfaces for three or four student nurses or dietetic interns. It provides sufficient room for clinical teaching or dietary department conferences.

Here are some of the organizational benefits we now enjoy. All salads are prepared in the main kitchen. Special orders for meat, vegetables, soups, creamed and egg dishes, as well as the odd orders, are sent to this department. All desserts come from the bakeroom. Juices, fruit and similar breakfast foods come from the storeroom. Special trays are set up on the floors, just as the general diets are but, of course, are carefully checked by the dietitian before being carried by the nurse to the patient. The student nurses still have food preparation duties, widely varied in scope to meet all dietary needs, but the amount of their time spent in this service is restricted. They have more time for clinical instruction with the dietitians; case studies; visiting patients; making out diet slips; carrying trays directly to the patient; studying the patients' charts and learning the significance of diet in the cure of the patient. At least 50 per cent of their time is spent in contact with the patient where as formerly it had been exploited by many assembly-line tasks such as making those 200 salads in an afternoon.

Six months ago, we modified our diet kitchen. Has the passage of time brought any regrets or lonesomeness for old haunts? Negative answers from all concerned.

Stop telling men not to worry; all thinking men do; and such only do the world's work. — *M. H. Fischer*, M.D.

Executive Position Wanted

Fully qualified as nursing orderly, supervision of accounting for dietary, medical equipment, and pharmacy departments, R.C.A.M.C.; Warrant officer in charge of R.C.A.F. station, Trenton Hospital; commissioned as medical statistical officer overseas; medical adjutant various R.C.A.F. stations in Canada. Age 46. Desires hospital appointment, preferably in Southern Ontario or B.C. Available after August 15th. James H. Caton, 11602-118th Street, Edmonton, Alberta.

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Australian Children's Hospital Has Self-contained School

One of the most outstanding facilities that the Royal Alexandra Hospital for Children, Sydney, Australia, is able to offer is, in conjunction with the Department of Education, a self-contained school in the hospital grounds for the education of handicapped children. Here, surrounded by fellow pupils who are similarly handicapped, the crippled child is able to make considerable progress without feeling isolated.

Testimony to its success is the number of pupils who proceed from it to distinguished State schools. The skill of the teachers is matched only by their infinite patience and it is an education in itself to watch the results that are obtained. Nor is the broader cultural side neglected, for the children have been taken to hear symphony orchestral concerts at the Sydney Town Hall. It is remarkable that last year the pupils were able to hold their first School Sports Day. Considering the handicaps from which these children suffer, this is an outstanding achievement. — *From the hospital's annual report 1953-54.*

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"Light work" is a phrase often associated with people who have had tuberculosis but many authorities say that it no longer has much meaning. First of all, the general condition of patients leaving sanatorium is immensely better than it was years ago. Then, too, jobs themselves have changed in recent years and machines have replaced heavy manual labour all through the employment field. The result is that only a small fraction of jobs remain which are not suitable for former tuberculosis patients. Surveys have shown that only about three per cent of the men and women who have been cured of tuberculosis are obliged to change their occupation when they are ready to take a job.—*"Brief Employment Facts", published by the Federal Department of Labour.*

The man whose authority is recent is always stern. — *Aeschylus*

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Cornwall General Hospital, (170 beds) Cornwall, Ontario, requires an Executive Housekeeper. Apply to the Superintendent, stating references, qualifications, experience and salary expected.

News Released by Hospital Supply Houses

By C.A.E.

Easier Diagnosis Promised by New Dental X-Ray Equipment

Radically-new dental x-ray equipment, with 100 per cent more x-ray output and a 40 per cent increase in voltage over previous G-E models, was announced recently by General Electric's X-Ray Department. It is being exhibited to dentists in all areas of the U.S. and Canada.

The higher voltage and output promise many gains both to the patient and the dentist in improved ability to diagnose and treat dental ailments.

Streamlined in design, the new x-ray units are meant to pace a growing trend among dentists toward the use of higher voltages, which accomplish five objectives long sought by the profession:

They reduce radiation exposure to the patient by as much as 60 per cent—made possible by shorter exposure times;

They make it possible to show widely different tissues on a single film—that is, bones, gums and teeth—whereas hitherto it has often been necessary to make more than one film to accomplish this;

They make it possible to move the x-ray unit farther from the patient. This reduces distortion of the image, since x-rays spread out from a point source;

The higher the voltage, the greater the ease with which x-rays penetrate tissues. This means that more useful x-rays reach the film, and there is less scattered radiation. Scattered rays tend to blur the image on the film;

Higher voltages produce a longer contrast scale, which permits more detail to be visible because of finer differentiation between tissue densities that are close together. This makes it more likely that diseased areas will be seen by the dentist.

Baxter Appoints Frohlich Agency

Baxter Laboratories, Inc. of Morton Grove, Ill., has appointed L. W. Frohlich and Co., Inc., as its advertising agency.

Baxter has been a pioneer and leader in the field of parenteral solutions since 1931. The company is noted for its many solutions including Travert, and for its accessories and equipment widely used for supplying the electrolyte, caloric and fluid needs of medical and surgical patients.

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The integrated parenteral program made possible by Baxter's range of solutions, blood donor and recipient equipment, and sets and accessories is used by many hospitals for their infusion and transfusion requirements.

A large staff of medical service representatives is available to help obtain maximum benefits of products to hospitals and the medical profession.

The company's main office and research laboratories are at Morton Grove, Ill. They have other laboratories at Acton, Ontario; Cleveland, Miss.; and Johannesburg, South Africa.

G. H. Wood Produces New Line of Protective Coatings

Branching out into a new field of enterprise, G. H. Wood and Company Limited are about to market seven new revoluntionary types of industrial protective coatings together with a range of suitable primers and solvents. Each of the coatings has its own special properties and specific uses.

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A complete new line of small engine-driven electric generating plants ranging in size from 500 to 2,500 watts is announced by D. W. Onan & Sons Inc., Minneapolis, Minnesota. Entirely Onan-built, these new air-cooled, gasoline-operated electric plants will provide greater output at less weight and lower cost. They employ heavy-duty, 4-cycle engines, designed specifically for long-life generating plant service.

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(Concluded on page 98)

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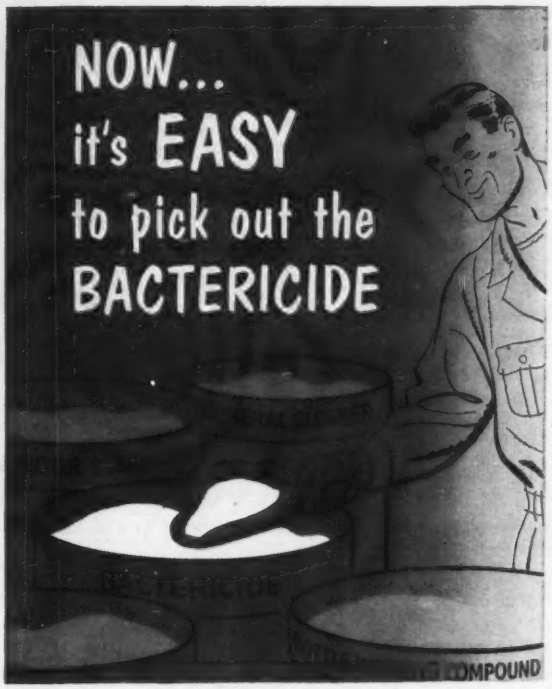

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Across The Desk

(Concluded from page 96)

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Because of their small size and high output per pound weight, the new AK and AJ models are highly suitable for mobile and portable applications. Their efficient air-cooling and sturdy cast-iron construction makes them ideal for heavy-duty service where installation space is at a premium.

Ohio-Heidbrink Catalogue

Complete information about the Ohio-Heidbrink line of surgical anesthesia apparatus and accessories is contained in a new 40-page illustrated catalogue available from the Ohio Chemical & Surgical Equipment Co. (A Division of Air Reduction Company, Incorporated), Madison 10, Wisconsin.

This new edition of the catalogue contains many major revisions and additions. Among these are the recently introduced No. 60 Infant Circle Absorber, the Fink modification of the Stephens-Slater valve, recalibrated easy-to-read flowmeters, and a more extensive line of intratracheal anesthesia accessories.

To obtain a copy of this new catalogue on "Ohio-Heidbrink Surgical Anesthesia Apparatus and Accessories", write to Ohio Chemical requesting Form No. 2145.

Oakite Introduces New Metal Brightener

Oakite Highlite, a new cleaner designed for the removal of residues and corrosion from stainless steel and copper equipment in hospitals, food plants, dairies, and restaurants, has recently been introduced by Oakite Products of Canada, Limited, manufacturers of industrial cleaning and sanitizing materials.

Combining acidic and abrasive properties in one material, Oakite Highlite is applied like a scouring powder with a pad or cellulose sponge. It is allowed to set for a short time, then removed by rinsing while brushing. In extensive field tests, the material has proved effective not only in removing beerstone and dried-on food deposits, but in delaying the retarnishing of surfaces. It has also been used to clean red tile floors with good results.

More information about this new cleaner is available in a special service report. Please write on letterhead to Oakite Products of Canada Limited, 65 Front Street E., Toronto, Ontario.

R. Stafford Edwards *Robert H. Andrews*

Edwards of Canada Elect Executives

Following a recent meeting of the Board of Directors of Edwards of Canada Limited, Owen Sound, Ontario, the following executive appointments were announced. Mr. R. Stafford Edwards was elected chairman of the board and Mr. Robert H. Andrews was elected president. Mr. Edwards is also president of the Edwards Company, Inc., Norwalk, Conn., and is a former president of the National Electrical Manufacturers Association. Mr. Andrews is a past director of the Canadian Electrical Manufacturers Association. The company manufactures a complete line of fire alarm and signalling systems for institutional, industrial and residential buildings.

Gestetner Remodel Premises

Gestetner (Canada) Limited, makers of the well-known Gestetner duplicating equipment, has just finished a complete remodelling of its Canadian head office at 117 King Street West, Toronto. The entire front of the building has been modernized, providing handsome showrooms at street level, with the remaining three floors used for offices and all necessary mechanical operations. An additional wing, closing off an old lane no longer in use, was completed last year.

A short distance from King and Bay Streets—one of Canada's busiest and most influential intersections—it reflects the widespread modernization this section of downtown Toronto has undergone, to keep pace with the growth of business.

New Merck Product

Crystalline Vitamin B_{12} the newest and most potent substance yet discovered for the treatment of anemia, is now being produced at the Valleyfield, Quebec, plant of Merck & Co. Limited, manufatcuring chemists.

In 1948 research workers in the Merck Research Laboratories announced the isolation of a red crystallin ecompound from liver. This compound, in minute quantities, produced amazing results in the treatment of pernicious anemia. It has rapidly replaced liver therapy for this dreaded disease.

In Merck's Valleyfield plant, Crystalline Vitamin B_{12} is produced by fermentation in a similar manner to penicillin and streptomycin. This is followed by a complex series of separation and purification steps until the tiny blood-red crystals are isolated.

Production of the local plant goes to pharmaceutical manufacturers for inclusion in tonics and prescription specialties. A further quantity is supplied to makers of animal feeds.

Index of Advertisers

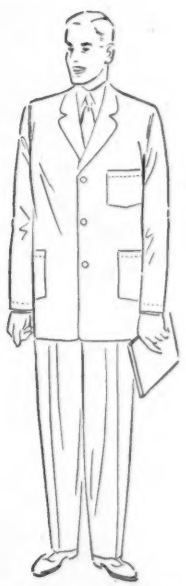
APRIL, 1955

Authorized as Second Class Mail, Post Office Department, Ottawa. The Canadian Hospital is published by The Canadian Hospital Association, 57 Bloor Street West, Toronto 5.

OPERATING ROOM Apparel and Equipment

... with traditional Corbett-Cowley workmanship and finest materials

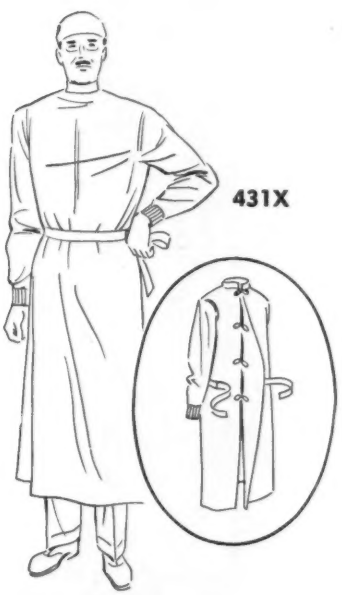
Your investment in Corbett-Cowley Operating Room Apparel is amply returned in long, hard service. Use of the best materials obtainable combines with traditional Corbett-Cowley workmanship to give you garments that will stand up under the most rigorous use. Patterns are cut full with plenty of room for comfort, and seams are reinforced at points of extra wear.



103

103. House Doctor's Coat

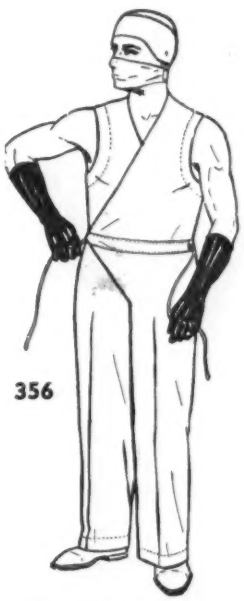
Made of bleached drill, this coat is both serviceable and neat in appearance. Fashioned with notched lapel collar, three pockets, detachable buttons and hemmed sleeves.



431X

431X. Surgeon's Bone Gown

Similar to our style 431, but with the addition of a flap which covers tie openings at the back, and is held by all-round belt. This feature makes gown more sterile. *Can be made in coloured, bleached or unbleached materials.*



356

356. Surgeon's Operating Suit

This popular one-piece garment (no buttons required) is in great demand for surgeon's work. The adjustable tie tape belt and one-piece feature, alone commend its use. Made from best quality bleached suiting. Stocked in even sizes 34-44. *Also available in colour—made to order.*

Sales Tax is added unless orders are accompanied by Regulation Sales Tax Exemption Certificates.

CORBETT-COWLEY
Limited

2738 Dundas St. W., Toronto 424 St. Helene St., Montreal

have CLEAN paper towels always handy!

So efficient — They eliminate line up or waiting for someone to finish drying. Economical dispensers can be located wherever convenient.

So sanitary—No handling soiled towels—no risk of infection. Brompton towels *touch no one's hands but those of the user.*

So soft — Brompton individual paper towels provide a fast . . . smooth . . . economical drying medium.

So economical — Save money with *low cost* Brompton paper towels.

Brompton K-20—These general service Kraft towels have maximum absorbency and are recommended for general washroom use.

Brompton W-20 — These white towels are unsurpassed in quality . . . are lint-free . . . soft . . . very absorbent . . . do not fall apart when wet. They can be used as industrial "white-wipes" to wash, polish or clean up anything.

Made in Canada by St. Lawrence Corporation Limited, Montreal, Que. Mills located at Dolbeau, East Angus and Three Rivers, Que., Nipigon and Red Rock, Ontario.

Wood's SANITATION FOR THE NATION

exclusive distributors

G. H. WOOD & COMPANY LIMITED

MONTREAL TORONTO VANCOUVER • BRANCHES THROUGHOUT CANADA